Star Discount Pharmacy specialty care

Endometriosis

Call: (877) 883-1392 Fax: (256) 429-2221

Patient Information: Name:________________ DOB:________ Gender: M ○ F ○

Address: ________________ City:________ State:_____ Zip: ______
Phone: ________ Alt. Phone: ________ Caregiver: ____________
Email: ________________ Height: ______ Weight:______
Allergies: ○ No Known ○ See Attached Charts ○ Other: ____________
Last 4 of SSN:

Prescriber Information **Please include front and back copies of insurance card.**

Name: ________________ NPI: ____________
Address: ________________ City: ________ State:_____ Zip:______
Phone:________ Fax: ________ Office Contact:____________

Statement of Medical Necessity (Please Attach All Medical Documentation)

Date of Diagnosis: ____________
ICD-10: ____________
Other: ____________
Is patient pregnant? ○ Yes ○ No
Confirmed by pregnancy test? ○ Yes ○ No

Symptoms Present: ○ Dysmenorrhea ○ Menorrhagia ○ Dyspareunia ○ Digestive Complications ○ Non-Menstrual Pelvic Pain ○ Other: ________
Diagnostic Procedure: ○ Pelvic Exam ○ Laparoscopy ○ Ultrasound ○ MRI ○ Other: ________

Prior Failed Treatments	Drug Name & Length of Treatment
○ Aromatase Inhibitors	
○ Combined Hormonal Contraceptives	
○ Contraceptives	
○ GnRH Agonists	
○ NSAIDS	
○ Opioids	
○ Oral Progestins	
○ Surgery	
○ Other	

Contraindications to Traditional Therapy?

Does the Patient Have:
○ Cardiovascular Disease ○ Yes ○ No
○ DVT or Embolism ○ Yes ○ No
○ Heavy Smoker (>= 15 cigarettes/day or 35 years old and smoke) ○ Yes ○ No
○ Peptic Ulcer or Stomach Bleeding ○ Yes ○ No
○ Renal Impairment ○ Yes ○ No

Product Delivery:
○ Patient's Home ○ Physician's Office ○ Pharmacy to Coordinate

Medication	Dosage & Strength	Directions	Qty	Refills
○ Orilissa	○ 150mg Tablet	○ Normal liver function or mild hepatic impairment: 150mg once daily for up to 24 months	28	
		○ Moderate Hepatic Impairment: 150mg once daily for up to 6 months	28	
	○ 200mg Tablet	○ Normal liver function or mild hepatic impairment: 200mg twice daily for up to 6 months	56	

Prescriber Signature (I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs)

Signature: ________________ Date: ________
Substitution Permitted

Signature: ________________ Date: ________
Dispense as Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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