

**1 PATIENT INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

**2 PRESCRIBER INFORMATION:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
Tax I.D.: \_\_\_\_\_  
Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**3 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 \_\_\_\_\_  
Does the patient have osteoporosis?  Yes  No  
Has impact to bone mineral density been considered?  Yes  No  
Does the patient have severe hepatic impairment?  Yes  No  
Diagnostic Procedure:  Pelvic Exam  Laparoscopy  Ultrasound  MRI  Other \_\_\_\_\_  
*For Uterine Fibroids:*  
Does the patient have iron deficiency anemia secondary to uterine fibroids?  Yes  No HGB \_\_\_\_\_ HCT \_\_\_\_\_  
Will the patient be using concomitant iron supplementation?  Yes  No  
*For Lupron®:* is this medication being used prior to fibroid surgery?  Yes  No

Medication	Indicate Drug Name and Length of Treatment:	Contraindications to Traditional Therapy?
<b>Prior Failed Treatments:</b>		Does the patient have:
<input type="checkbox"/> Aromatase Inhibitors	_____	Cardiovascular Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Combined Hormonal Contraceptives	_____	DVT or Embolism <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Contraceptives	_____	Heavy Smoker (>= 15 cigarettes/day or 35 years old and smoke) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> GnRH Agonists	_____	Peptic Ulcer or Stomach Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> NSAIDS	_____	Renal Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Intrauterine Devices	_____	
<input type="checkbox"/> Iron Supplementation	_____	<b>Contraindications to Intrauterine Devices:</b>
<input type="checkbox"/> Opioids	_____	Congenital or acquired uterine anomaly distorting the uterine cavity <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Oral Progestins	_____	History of pelvic inflammatory disease (no subsequent pregnancy) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgery	_____	Postpartum endometritis or infected abortion in the past 3 months <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Tranexamic Acid	_____	
<input type="checkbox"/> Other	_____	

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

**4 PICK UP OR DELIVERY:**  Delivery to Patient's Home  Delivery to Physician's Office  Pharmacy to Coordinate

**5 INSURANCE INFORMATION:** Please Include Front and Back Copies of Pharmacy and Medical Card

**PRESCRIPTION INFORMATION:**

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> LUPRON DEPOT®	<input type="checkbox"/> 3.75mg Kit	<input type="checkbox"/> Inject 3.75mg single IM every month	1	
	<input type="checkbox"/> 11.25mg Kit	<input type="checkbox"/> Inject 11.25mg single IM once every three-month	1	
<input type="checkbox"/> MAKENA®	<input type="checkbox"/> 275mg/1.1ml Autoinjector	<input type="checkbox"/> Administer 275mg/1.1ml SC once weekly in the back of either upper arm by a Healthcare Provider until week 37 of gestation or delivery, whichever comes first		
	<input type="checkbox"/> 250mg/1ml Single-Dose Vial <input type="checkbox"/> 1250mg/5ml Multi-Dose Vial	<input type="checkbox"/> Administer 250mg (1ml) IM once weekly in the upper quadrant of the gluteus maximus by a Healthcare Provider until week 37 of gestation or delivery, whichever comes first		
<input type="checkbox"/> MYFEMBREE®	<input type="checkbox"/> Fixed-dose combination containing relugolix 40mg, estradiol 1mg and norethindrone acetate 0.5mg	<input type="checkbox"/> Take one tablet orally once daily	28	
<input type="checkbox"/> ORIAHNN®	<input type="checkbox"/> Morning (AM) capsule: elagolix 300mg, stradiol 1mg, norethindrone acetate 0.5mg	<input type="checkbox"/> Take one capsule orally in the morning	28	
	<input type="checkbox"/> Evening(PM) capsule: elagolix 300mg	<input type="checkbox"/> Take one capsule orally in the evening	28	
<input type="checkbox"/> ORILISSA®	<input type="checkbox"/> 150mg Tablet	<input type="checkbox"/> Normal liver function or mild hepatic impairment: 150mg once daily for up to 24 months	28	
		<input type="checkbox"/> Moderate hepatic impairment: 150mg once daily for up to 6 months	28	
	<input type="checkbox"/> 200mg Tablet	<input type="checkbox"/> 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: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Substitution Permitted**

**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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