



# ENDOMETRIOSIS SPECIALTY CARE PROGRAM

Phone: **856-963-4742** • Fax: **856-541-8580**



## 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 \_\_\_\_\_  
 Diagnostic Procedure:  Pelvic Exam  Laparoscopy  Ultrasound  MRI  Other \_\_\_\_\_

Medication		Contraindications to Traditional Therapy?
<b>Prior Failed Treatments:</b> <input type="checkbox"/> Aromatase Inhibitors _____ <input type="checkbox"/> Combined Hormonal Contraceptives _____ <input type="checkbox"/> Contraceptives _____ <input type="checkbox"/> GnRH Agonists _____ <input type="checkbox"/> NSAIDS _____ <input type="checkbox"/> Opioids _____ <input type="checkbox"/> Oral Progestins _____ <input type="checkbox"/> Surgery _____ <input type="checkbox"/> Other _____	<b>Indicate Drug Name and Length of Treatment:</b> _____ _____ _____ _____ _____ _____ _____ _____ _____	Does the patient have: <input type="checkbox"/> Cardiovascular Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DVT or Embolism <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Heavy Smoker (>= 15 cigarettes/day or 35 years old and smoke) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Peptic Ulcer or Stomach Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Renal Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No

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

## 4 PRODUCT DELIVERY: Patient's Home 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"/> ORILISSA™	<input type="checkbox"/> 150 mg Tablet	<input type="checkbox"/> Normal liver function or mild hepatic impairment: 150 mg once daily for up to 24 months	28	
		<input type="checkbox"/> Moderate hepatic impairment: 150 mg once daily for up to 6 months	28	
	<input type="checkbox"/> 200 mg Tablet	<input type="checkbox"/> Normal liver function or mild hepatic impairment: 200 mg twice daily for up to 6 months	56	
<input type="checkbox"/> _____	_____	_____		

**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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