



WOMEN'S HEALTH 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 _____
 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?
Prior Failed Treatments:		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	_____	Contraindications to Intrauterine Devices:
<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 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"/> LUPRON DEPOT®	<input type="checkbox"/> 3.75mg Kit	<input type="checkbox"/> Inject 3.75mg IM every month	1	
	<input type="checkbox"/> 11.25mg Kit	<input type="checkbox"/> Inject 11.25mg IM once for a three-month treatment course	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"/> ORIAHNN™	<input type="checkbox"/> 300mg/1mg/0.5mg capsule and 300mg capsule	<input type="checkbox"/> One elagolix, estradiol, and norethindrone acetate 300mg/1mg/0.5mg capsule in the morning (AM), and one elagolix 300mg capsule in the evening (PM) for up to 24 months	56	
<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"/> 200mg Tablet	<input type="checkbox"/> Moderate hepatic impairment: 150mg once daily for up to 6 months <input type="checkbox"/> Normal liver function or mild hepatic impairment: 200mg twice daily for up to 6 months	28	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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