Dierbergs pharmacy SPECIALTY CARE

ENDOMETRIOSIS SPECIALTY CARE PROGRAM

Phone: **844-283-6308** • Fax: **844-965-9849**

CPPA ACCREDITED

KLOUDSCRIPT Community Led Specialty Pharmacy Care

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

Prior Failed Treatments: / **Indicate Drug Name and 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 Diseases ❑ 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

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
❑ ORILISSA™	❑ 150 mg Tablet	❑ **Normal liver function or mild hepatic impairment:** 150 mg once daily for up to 24 months	28	
		❑ **Moderate hepatic impairment:** 150 mg once daily for up to 6 months	28	
	❑ 200 mg Tablet	❑ **Normal liver function or mild hepatic impairment:** 200 mg 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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