



Women's Health Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____ Sex: Male Female Height: _____ Weight: _____ lbs _____ kg _____
 SSN #: XXX-XX-____ Known Allergies: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____ Primary Language: _____
 Alternate Caregiver Name: _____ Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____ Secondary Insurance: _____
 Policy: _____ Group#: _____ Policy: _____ Group#: _____

Diagnosis

- N80.0 Endometriosis of uterus
- N80.1 Endometriosis of ovary
- N80.2 Endometriosis of fallopian tube
- N80.3 Endometriosis of pelvic peritoneum
- N80.4 Endometriosis of rectovaginal septum & vagina
- N80.5 Endometriosis of intestines
- Other: _____ ICD 10 code: _____
- N80.6 Endometriosis in scar of skin
- N80.8 Endometriosis of other unspecified sites
- N80.9 Endometriosis site unspecified
- D25.9 Uterine leiomyoma, unspecified
- Z30.017 Implantable subdermal contraceptive
- Z30.46 Encounter for surveillance of implantable subdermal contraceptive

Clinical Information

Please attach clinical office notes and diagnostic testing, if available, to expedite the prior authorization.

Has patient had prior treatment for this diagnosis? Yes No
 Date(s) of previous therapy and medication: _____
 For Lupron®, will patient be taking oral Norethindrone? Yes No Anticipated injection date: ____/____/____

Prescription

Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Lupaneta Pack®	<input type="checkbox"/> 3.75mg/5mg pack (1-month)	Inject intramuscularly once every 4 weeks and take 1 tablet orally once daily	#1 Kit	
	<input type="checkbox"/> 11.25mg/5mg pack (3-month)	Inject intramuscularly once every 12 weeks and take 1 tablet orally once daily		
<input type="checkbox"/> Lupron Depot®	<input type="checkbox"/> 3.75mg kit (1-month)	Inject intramuscularly once every 4 weeks	#1 Kit	
	<input type="checkbox"/> 11.25mg kit (3-month)	Inject intramuscularly once every 12 weeks		
<input type="checkbox"/> Nexplanon®	68mg Implant	Implant 1 rod subdermally once every 3 years	#1	0 refills
<input type="checkbox"/> Orilissa™	<input type="checkbox"/> 150mg tablet	Take 1 tablet by mouth once daily	#28	
	<input type="checkbox"/> 200mg tablet	Take 1 tablet by mouth twice daily	#56	
<input type="checkbox"/> Oriahnn™	300/1/0.5mg and 300mg Dose pack	Take 1 capsule orally twice daily following package instructions	#56	
<input type="checkbox"/> Zoladex®	3.6mg Implant	Prescriber to implant 3.6mg subcutaneously once every 4 weeks	#1	

Is patient new to this therapy: YES NO | Ship to: Patient Office Other

Prescriber Data

Prescriber Name: _____ DEA#: _____ NPI: _____
 Practice Name: _____ Contact: _____ Preferred Method: Phone Fax Email
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Email: _____

My signature below authorizes Restore Rx, Inc. staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx, Inc. Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said process.

Physician Signature: _____ Date: _____ This prescription will be filled generically unless prescriber writes "DAW" in the box to the right.

fax referral to: 901-388-0407 | phone: 877-388-0507 | www.restorerx.com