Women's Health Enrollment Form

Date: _____

Patient Data

Patient Name: _____ Birthdate: _____
SSN #: XXX-XX-_____
Address: _____
Home Phone: _____ Cell Phone: _____
Alternate Caregiver Name: _____

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ lbs ☐ kg ☐
Known Allergies: _____
City: _____ State: _____ Zip: _____
Primary Language: _____
Phone of Caregiver: _____

Ins. Data

Primary Insurance: _____
Policy: _____ Group#: _____

Secondary Insurance: _____
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
- ☐ 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 sudermal contraceptive
- ☐ Other: _____ ICD 10 code: _____

Clinical Information

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

Has patient had prior treament 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
☐ Lupron Depot®	☐ 3.75mg kit (1-month)	Inject intramuscularly once every 4 weeks	#1 Kit	
	☐ 11.25mg kit (3-month)	Inject intramuscularly once every 12 weeks		
☐ Myfembree®	40/1/0.5mg tablet	Take 1 tablet orally once daily	#28	
☐ Nexplanon®	68mg Implant	Implant 1 rod subdermally once every 3 years	#1	0 refills
☐ Orilissa™	☐ 150mg tablet	Take 1 tablet by mouth once daily	#28	
	☐ 200mg tablet	Take 1 tablet by mouth twice daily	#56	
☐ Oriahnn™	300/1/0.5mg and 300mg *Dose pack*	Take 1 capsule orally twice daily following package instructions	#56	
☐ 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: _____
Practice Name: _____
Address: _____
City: _____ State: _____ Zip: _____

DEA#: _____ NPI: _____
Contact: _____ Preferred Method: ☐ Phone ☐ Fax ☐ Email
Phone: _____ Fax: _____
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. ☐