



Women's Health Enrollment Form

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

- | | |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> N80.0 Endometriosis of uterus | <input type="checkbox"/> N80.6 Endometriosis in scar of skin |
| <input type="checkbox"/> N80.1 Endometriosis of ovary | <input type="checkbox"/> N80.8 Endometriosis of other unspecified sites |
| <input type="checkbox"/> N80.2 Endometriosis of fallopian tube | <input type="checkbox"/> N80.9 Endometriosis site unspecified |
| <input type="checkbox"/> N80.3 Endometriosis of pelvic peritoneum | <input type="checkbox"/> D25.9 Uterine leiomyoma, unspecified |
| <input type="checkbox"/> N80.4 Endometriosis of rectovaginal septum & vagina | <input type="checkbox"/> Z30.017 Implantable subdermal contraceptive |
| <input type="checkbox"/> N80.5 Endometriosis of intestines | <input type="checkbox"/> Z30.46 Encounter for surveillance of implantable subdermal contraceptive |
| <input type="checkbox"/> 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 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"/> 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"/> Myfembree®	40/1/0.5mg tablet	Take 1 tablet orally once daily	#28	
<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: _____
 Address: _____ Phone: _____ Fax: _____
 City: _____ State: _____ Zip: _____ Key Contact#: _____

My signature below authorizes Value Specialty Pharmacy 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 Value Specialty 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: 844-812-6227 | phone: 855-265-8008 | www.vsprx.com