Women's Health Enrollment Form

RESTORE Rx SPECIALTY PHARMACY

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
- ☐ N80.6 Endometriosis in scar of skin
- ☐ N80.8 Endometriosis of other unspecified sites
- ☐ N80.9 Endometriosis site unspecified
- ☐ D25.9 Uterine leiomyoma, unspecified

☐ 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		
☐ Orilissa™	☐ 150mg tablet	☐ Take 1 tablet by mouth once daily	#28	
	☐ 200mg tablet	☐ Take 1 tablet by mouth twice daily	#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: _____
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. ☐