ENDOMETRIOSIS SPECIALTY CARE PROGRAM

Phone: **888-623-3133** • Fax: **844-673-2245**

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: _____

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3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____ Other: _____

Severity Assessment: ❑ Stage I ❑ Stage II ❑ Stage III ❑ Stage IV

Symptoms Present: ❑ Dysmenorrhea ❑ Menorrhagia ❑ Dyspareunia ❑ Digestive Complications ❑ 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	_____
❑ Oral Progestins	_____
❑ Surgery	_____
❑ Other	_____

Contraindications

Does the patient have:

❑ Anxiety or Depression ❑ Yes ❑ No
❑ Cardiovascular Diseases ❑ Yes ❑ No
❑ DVT or Embolism ❑ Yes ❑ No
❑ Heavy Smoker (>= 15 cigarettes/day or 35 years old and smoke) ❑ Yes ❑ No
❑ Osteoporosis? ❑ Yes ❑ No
❑ Peptic Ulcer or Stomach Bleeding ❑ Yes ❑ No
❑ Renal Impairment ❑ Yes ❑ No
❑ Severe Hepatic Impairment? ❑ Yes ❑ No

Laboratory Tests

Please attach the following:

❑ Liver Enzymes
❑ Pregnancy Test Results
❑ T-Score/DEXA Scan
❑ Other: _____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

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.