Kohll's Rx SPECIALTY CARE

WOMEN'S HEALTH SPECIALTY CARE PROGRAM

Phone: **877-324-2501** • Fax: **888-972-4110**

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: _____

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

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

Is patient pregnant? ❑ Yes ❑ No Confirmed by pregnancy test ❑ Yes ❑ No

Symptoms Present: ❑ Dysmenorrhea ❑ Menorrhagia ❑ Dyspareunia ❑ Digestive Complications ❑ Non-Menstrual Pelvic Pain

❑ Other _____

Does the patient have osteoporosis? ❑ Yes ❑ No

Has impact to bone mineral density been considered? ❑ Yes ❑ No

Does the patient have severe hepatic impairment? ❑ Yes ❑ No

Diagnostic Procedure: ❑ Pelvic Exam ❑ Laparoscopy ❑ Ultrasound ❑ MRI ❑ Other _____

For Uterine Fibroids:

Does the patient have iron deficiency anemia secondary to uterine fibroids? ❑ Yes ❑ No HGB _____ HCT _____

Will the patient be using concomitant iron supplementation? ❑ Yes ❑ No

For Lupron®: is this medication being used prior to fibroid surgery? ❑ Yes ❑ No

Medication

Prior Failed Treatments: / **Indicate Drug Name and Length of Treatment:**

- ❑ Aromatase Inhibitors _____
- ❑ Combined Hormonal Contraceptives _____
- ❑ Contraceptives _____
- ❑ GnRH Agonists _____
- ❑ NSAIDS _____
- ❑ Intrauterine Devices _____
- ❑ Iron Supplementation _____
- ❑ Opioids _____
- ❑ Oral Progestins _____
- ❑ Surgery _____
- ❑ Tranexamic Acid _____
- ❑ Other _____

Contraindications to Traditional Therapy?

Does the patient have:

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

Contraindications to Intrauterine Devices:

Congenital or acquired uterine anomaly distorting the uterine cavity	❑ Yes	❑ No
History of pelvic inflammatory disease (no subsequent pregnancy)	❑ Yes	❑ No
Postpartum endometritis or infected abortion in the past 3 months	❑ Yes	❑ No

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

4 PICK UP OR DELIVERY: ❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

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

PRESCRIPTION INFORMATION:

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ LUPRON DEPOT®	❑ 3.75mg Kit	❑ Inject 3.75mg IM every month	1	
	❑ 11.25mg Kit	❑ Inject 11.25mg IM once for a three-month treatment course	1	
❑ MAKENA®	❑ 275mg/1.1ml Autoinjector	❑ Administer 275mg/1.1ml SC once weekly in the back of either upper arm by a Healthcare Provider until week 37 of gestation or delivery, whichever comes first		
	❑ 250mg/1ml Single-Dose Vial ❑ 1250mg/5ml Multi-Dose Vial	❑ Administer 250mg (1ml) IM once weekly in the upper quadrant of the gluteus maximus by a Healthcare Provider until week 37 of gestation or delivery, whichever comes first		
❑ ORIAHNN™	❑ 300mg/1mg/0.5mg capsule and 300mg capsule	❑ One elagolix, estradiol, and norethindrone acetate 300mg/1mg/0.5mg capsule in the morning (AM), and one elagolix 300mg capsule in the evening (PM) for up to 24 months	56	
❑ ORILISSA®	❑ 150mg Tablet	❑ **Normal liver function or mild hepatic impairment:** 150mg once daily for up to 24 months	28	
		❑ **Moderate hepatic impairment:** 150mg once daily for up to 6 months	28	
	❑ 200mg Tablet	❑ **Normal liver function or mild hepatic impairment:** 200mg 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.