MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

CONTRACEPTIVES

Ph: 832-365-3420 Fax: 855-595-2955

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____

Home Address:_____ City:_____ State:_____ Zip Code:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____

Weight:_____lbs. Emergency Contact:_____

Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:		Secondary Insurance:	
ID#:	RxBin:	ID#:	RxBin:
RxGroup:	Pcn:	RxGroup:	Pcn:

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

MEDICATION	DOSE	DIRECTIONS	QTY	REFILLS
☐ ANNOVERA	☐ .15MG/.013MG SYSTEM	☐ Follow package instructions and use as directed by physician	[1]	
☐ KYLEENA	☐ 19.5MG SYSTEM	☐ To be inserted by HCP	[1]	
☐ LO LOESTRIN FE	☐ 1MG/10MG TABLET	☐ Follow package instructions and use as directed by physician	[28] or [84]	
☐ MIRENA	☐ 52MG SYSTEM	☐ To be inserted by HCP	[1]	
☐ NATAZIA	☐ 3MG/2MG/1MG TABLET	☐ Follow package instructions and use as directed by physician	[28] or [84]	
☐ NEXTSELLIS	☐ 3MG/2MG/1MG TABLET	☐ Follow package instructions and use as directed by physician	[28] or [84]	
☐ NUVARING	☐ .12MG/.015MG SYSTEM	☐ Follow package instructions and use as directed by physician	[1] or [3]	
☐ PHEXXI	☐ 1.8%/1%/.4% GEL KIT	☐ Follow package instructions and use as directed by physician	[1]	
☐ SKYLA	☐ 13.5MG SYSTEM	☐ To be inserted by HCP	[1]	
☐ SLYND	☐ 4MG TABLET	☐ Follow package instructions and use as directed by physician	[28] or [84]	
☐ TWIRLA	☐ 120MCG/30MCG PATCH	☐ Follow package instructions and use as directed by physician	[3] or [9]	

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____

Address: City: State: Zip Code:

Phone: Fax:

***Prescriber Signature:** **Date:**

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Please fax completed form to 1 (855) 595-2955