MAIN POINT OF CONTACT

Name: _____

Phone: _____

ALLIED PHARMACY

WOMENS HEALTH

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
☐ ADDYI	☐ 100MG TABLET	☐ Take 1 tablet by mouth at bedtime	[30]	
☐ BIJUVA	☐ 0.5MG/100MG CAPSULE ☐ 1MG/100MG CAPSULE	☐ Take 1 capsule by mouth once in the evening with food	[30]	
☐ BONJESTA	☐ 20MG/20MG TABLET	☐ Take 1 tablet by mouth twice daily	[60]	
☐ DICLEGIS	☐ 10MG/10MG TABLET	☐ Take 1 tablet by mouth twice daily		
☐ CLOMID	☐ 50MG TABLET	☐ Take_____tablets by mouth once a day for_____days		
☐ COMBIPATCH	☐ .05MG/.14MG PATCH ☐ .05MG/.25MG PATCH	☐ Follow package instructions and use as directed by physician	[8]	
☐ DUAVEE	☐ 0.45MG/20MG TABLET	☐ Take_____mg by mouth daily	[30]	
☐ IMVEXXY	☐ 4MCG STARTER KIT ☐ 10MCG STARTER KIT ☐ 4MCG MAINTENANCE KIT ☐ 10MCG MAINTENANCE KIT	☐ Follow package instructions and use as directed by physician	[8] or [18]	
☐ LUPRON GYN	☐ 3.75MG KIT ☐ 11.25MG KIT	☐ Inject_____mg IM every_____month(s) in healthcare setting	1 KIT	
☐ MYFEMBREE	☐ 40MG/1MG/0.5MG TABLET	☐ Take 1 tablet by mouth every day	[28]	
☐ ORIAHNN	☐ 300MG/1MG/0.5MG CAPSULE	☐ Take 1 capsule by mouth twice daily	[56]	

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:**

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone numbers set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

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

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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
☐ ORILISSA	☐ 150MG TABLET ☐ 200MG TABLET	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily	[28]	
☐ OSPHENA	☐ 60MG TABLET	☐ Take 1 tablet by mouth once daily with food	[30]	
☐ PREGNYL	☐ 10000U VIAL		_____VIAL(S)	
☐ PREMPRO	☐ .3MG/1.5MG TABLET ☐ .45MG/1.5MG TABLET ☐ .625MG/2.5MG TABLET ☐ .625MG/5MG TABLET	☐ Take 1 tablet by mouth once daily	[28]	
☐ TIVDAK	☐ 40MG VIAL	☐ Administer 2mg/kg by IVPB in healthcare setting	_____VIAL(S)	
☐ VEOZAH	☐ 45MG TABLET	☐ Take 1 tablet by mouth once daily	[30]	
☐ XACIATIO	☐ 2% GEL	☐ Administer 1 applicatorful intervaginally once a day	_____TUBE(S)	
☐ ZURZUAVE	☐ 20MG CAPSULE ☐ 25MG CAPSULE ☐ 30MG CAPSULE	☐ Take_____mg by mouth once daily	[28]	

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Prescriber Name:_____ NPI#:_____
Address: City: State: Zip Code:
Phone: Fax:
***Prescriber Signature:** **Date:**

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