

Patient Information			Prescriber Information	
Patient Name:	DOB:		Prescriber's Name:	
Address:			NPI#:	
City:	State:	Zip:	DEA#:	License#:
Phone:	Alternate Phone:	SSN:	Address:	
Height:	Weight:	Allergies:	Phone:	Fax:
Emergency Contact:		Phone:	Contact Person:	

**Client Considerations**

**Diagnosis (ICD 10):**

- 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 and vagina
- N80.5 Endometriosis of intestine
- N80.6 Endometriosis in cutaneous scar
- N80.8 Other endometriosis
- N80.9 Endometriosis, unspecified

Other (please specify): \_\_\_\_\_

Medication	Dose/Strength	Directions for Use	Qty	Refills
<b>LUPRON DEPOT™</b> (leuprolide acetate)	3.75mg IM	Once a month.		
	11.25mg IM	Once every 3 months.		
<b>LUPANETA PACK™</b> (leuprolide acetate)	3.75 mg IM Includes norethindrone acetate 5 mg tablets	Once a month. <i>Take one by mouth daily.</i>	#30	
	11.25 mg IM Includes norethindrone acetate 5 mg tablets	Once every 3 months. <i>Take one by mouth daily.</i>	#90	

By signing this form I authorize AleraCare and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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**Prescriber's Signature**

 \_\_\_\_\_  
**Date**