aleracare
advanced specialty pharmacy

Endometriosis
Referral Form

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 Contant:	Phone:		Contact Person:	

Is the patient pregnant, planning a pregnancy or nursing: ◯ Yes ◯ No

Does the patient need interpreter services: ◯ Yes ◯ No

Documentation (Required)

◯ Insurance Card (front and back) ◯ Current Medications ◯ History/Progress Notes

Specific Labs Needed (note: send ALL labs, must include specific labs listed here)

◯ Other: _____

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
◯ **LUPRON DEPOT™** (leuprolide acetate)	◯ 3.75mg IM ◯ 11.25mg IM	◯ Once a month. ◯ Once every 3 months.		
◯ **LUPANETA PACK™** (leuprolide acetate)	◯ 3.75 mg IM Includes norethindrone acetate 5 mg tablets	◯ Once a month. *Take one by mouth daily.*	#30	
	◯ 11.25 mg IM Includes norethindrone acetate 5 mg tablets	◯ Once every 3 months. *Take one by mouth daily.*	#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.

Prescriber's Signature _____ **Date** _____