Endocrinology

Select Pharmacy

Avita
avitapharmacy.com

DATE: _____ **NEEDS BY DATE:** _____ **SHIP TO:** ❑ PATIENT ❑ OFFICE - FIRST DOSE ❑ OFFICE - ALL DOSES ❑ OTHER _____

PATIENT INFORMATION

ALL INFORMATION IS CONFIDENTIAL AND USED FOR CLINICAL PURPOSES ONLY

Patient Name		Preferred Name	
Main Phone	Alternative Phone	Date of Birth	Social Security #
Address		City, State, Zip	

Sex
❑ Male ❑ Female ❑ Intersex ❑ MtF Female ❑ FtM Male ❑ other:

Gender Identity ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ other:	Pronouns

Allergies

PRESCRIBER INFORMATION

Prescriber Name		Entity/Organization
Address		City, State, Zip
Office Contact	Tel	Fax

INSURANCE: PLEASE FAX BOTH SIDES OF PRESCRIPTION CARD AND MEDICAL CARD

CLINICAL INFORMATION

Diagnosis: ❑ N80.0 Endometriosis ❑ Pelvic Pain ❑ N92.1 Excessive Menstration ❑ D25.9 Uterine Leiomyomata (fibroids)
❑ Premenopausal Ovarian Ablation ❑ C50.919 Breast Cancer ❑ C61 Advanced Prostate Cancer ❑ E30.1 Precocious Puberty
❑ Other: _____ ❑ ICD-10:

Patient Weight	Patient Height	Bone Density Test Result
❑ Normal Liver Function	❑ Negative Pregnancy Test	Follow Up With Prescriber: ❑ 3 Months ❑ 6 Months ❑ 9 Months ❑ 12 Months

Patient Allergies

Other Notes/History:

PRESCRIPTION

❑ Sent Using Attached Form ❑ Faxed Separately ❑ E-Prescribed ❑ Phoned In ❑ Transfer

Transferring Pharmacy	Phone	Medications

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The pharmacy can only accept faxed prescriptions directly from a prescriber's office. In order for a brand name product to be dispensed, the prescriber must indicate "Brand Necessary" or "Brand Medically Necessary" or any required state-specific language. By submitting this form, you are authorizing the pharmacy and its representatives to act on your behalf to obtain prior authorizations for the prescribed medication(s). We will also pursue available copay and financial assistance on behalf of your patients when available.

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PATIENT INFORMATION

Patient Name	Date of Birth
Patient Address	

PRESCRIBER INFORMATION

Prescriber Name	Entity/Organization	
Address	City, State, Zip	
Prescriber Type ❑Physician (MD or DO) ❑ Nurse Practitioner ❑ Physician's Assistant	Supervising Physician (If prescriber is a NP or PA):	
Office Contact	Tel	Fax
DEA #	NPI #	TAX ID

PRESCRIPTION INFORMATION			QUANTITY	REFILLS
GYNECOLOGY:				
❑ Lupron Depot® ❑ Lupron Depot - 3®	❑ 3.75 mg ❑ 11.25 mg	❑ Inject intramuscularly (IM) once monthly ❑ Inject intramuscularly (IM) every 3 MONTHS	_____	_____
❑ Norethindrone Tablets	5 mg	Take 1 tablet by mouth once daily	_____	_____
PEDIATRICS:				
❑ Lupron Depot Peds®	❑ 7.5 mg ❑ 11.25 mg ❑ 15 mg	Inject intramuscularly (IM) once monthly	_____	_____
UROLOGY:				
❑ Lupron Depot® ❑ Lupron Depot - 3® ❑ Lupron Depot - 4® ❑ Lupron Depot - 6®	❑ 7.5 mg ❑ 22.5 mg ❑ 30 mg ❑ 45 mg	❑ Inject intramuscularly (IM) once monthly ❑ Inject intramuscularly (IM) every 3 MONTHS ❑ Inject intramuscularly (IM) every 4 MONTHS ❑ Inject intramuscularly (IM) every 6 MONTHS	_____	_____

Signature **Date**

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