

Start Date _____ **PATIENT INFORMATION**

Patient Name: _____

Date of Birth: ____/____/____ Male Female (Childbearing) SSN: ____ - ____ - ____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (____) - ____ - _____ Alternate Phone: (____) - ____ - _____ email: _____

Preferred method of contact: Phone Email Text Other: _____ Height: _____ in Weight: _____ lb

Allergies: _____ Medications or Medication list: _____

ICD-10 Code

Please attach additional pages if necessary, including front and back of insurance card

PRESCRIBER INFORMATION

Prescriber Name: _____

Office Phone: (____) - ____ - _____ Fax: (____) - ____ - _____ Contact: _____

Clinic/Hospital Affiliation: _____

Address: _____ City: _____ State: _____ Zip: _____

License #: _____ NPI #: _____ Medicaid Provider #: _____

PRESCRIPTION INFORMATION

PRODUCT NAME	DIRECTIONS	QUANTITY TO DISPENSE	REQUESTED DELIVERY DATE	REFILLS
<input type="checkbox"/> LUPANETA PACK	<input type="checkbox"/> LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 3.75 MG INJECTION IM Monthly+ NORETHINDRONE 5 MG TABLETS, ONE TABLET BY MOUTH DAILY <small>* DISCLAIMER LUPRON 3.75 MG + 30 NORETHINDRONE ACETATE 5MG TO BE FILLED UPON DENIAL</small>	#1 - 3.75mg PFS and #30 tablets		
	<input type="checkbox"/> LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 11.25 MG INJECTION IM Q 3 MONTHS + NORETHINDRONE 5 MG TABLETS, ONE TABLET BY MOUTH DAILY <small>* DISCLAIMER LUPRON 11.25 MG + 90 NORETHINDRONE ACETATE 5MG TO BE FILLED UPON DENIAL</small>	#1 - 11.25g PFS and #90 tablets		
<input type="checkbox"/> LUPRON DEPOT	<input type="checkbox"/> LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 3.75 MG INJECTION IM Monthly	#1 - 3.75mg PFS		
	<input type="checkbox"/> LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 11.25 MG INJECTION IM Q 3 MONTHS	#1 - 11.25mg PFS		
<input type="checkbox"/> ORILISSA	<input type="checkbox"/> Take 150mg by mouth daily	#28 - 150mg tablets		
	<input type="checkbox"/> Take 200mg by mouth twice daily	#56 - 200mg tablets		

Other Medication: _____ Strength: _____ Qty: _____ Refill _____ times

Directions: _____

Prescriber's signature: _____ Date: ____/____/____

, I authorize CoxHealth at Home and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

SHIPPING INFORMATION

injections to be given by: Physician/Clinic CoxHealth at Home RN Date Shipment Needed By: ____/____/____