Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

INFINITY CARE SOLUTIONS
1204 SE 28th St, Suite 2
Bentonville, AR 72712
Phone: 844-414-5805
Fax: 855-422-2400

OB/GYN Referral Form

Ship to: ❑Patient ❑Prescriber ❑ Pick Up (location):_____ Date Needed:_____

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI#: DEA#
City: State: Zip:	Address:
Phone: ( ) Alt Phone: ( )	City: State: Zip:
Emergency Contact Name:	Phone: ( ) Fax: ( )
Emergency Contact Phone: ( )	Nurse/Key Office Contact:
Patient Soc. Sec#: Date of Birth: / /	Tax ID#:
Sex: ❑ Male ❑Female Weight lbs/kg Height	
Allergies:	

CLINICAL INFORMATION ***(Please FAX recent clinical notes, labs, tests & current medication list with prescription)***

Diagnosis

❑ Moderate to severe pain associated with endometriosis

ICD-10 code: _____

❑Other_____

Date of diagnosis (or years with disease) _____

Do any of the following apply to the patient?

- ❑ Moderate hepatic impairment (Child Pugh Class B)
- ❑ Severe hepatic impairment (Child Pugh Class C)
- ❑ Osteoporosis
- ❑ Dyspareunia
- ❑ Currently pregnant or pregnancy possible
- ❑ Postmenopausal

Prior and Current Treatment *(please attach list if necessary)*

Is the patient currently receiving treatment or previously been treated for the diagnosis indicated? ❑Yes ❑No

- ❑ NSAIDs _____ Length of therapy: _____
- ❑ Oral contraceptives _____ Length of therapy: _____
- ❑ Lupron_____ Length of therapy: _____
- ❑ Synarel_____ ___ Length of therapy: _____
- ❑ Zoladex_____ Length of therapy: _____
- ❑ Other _____ Length of therapy: _____

Does the patient have any contraindications or intolerances to any medications? ❑Yes ❑No

If yes, please name medication and describe contraindication or reaction? _____

PRESCRIPTION

DRUG	DIRECTIONS	QUANTITY	DOSAGE FORM	REFILLS
Orilissa®	❑ Take 1 tablet (150mg) by mouth once daily.	❑ 28	❑ 150mg tablets	____
	❑ Take 1 tablet (200mg) by mouth twice daily.	❑ 56	❑ 200mg tablets	____

INSURANCE INFORMATION: PLEASE FAX COPY OF INSURANCE CARDS (FRONT & BACK)

To Prescriber: *By signing this form and utilizing our services, you are authorizing Infinity Care Solutions, a division of Infinity Compounding Solutions, LLC, its agents and employees, to serve as your prior authorization designated agent in dealing with medical or prescription claims payers, processors and other entities.*

Date: _____ _____ _____

DISPENSE AS WRITTEN **MAY SUBSTITUTE**