



OB/GYN Referral Form

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



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

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Patient Name: _____			Prescriber Name: _____		
Address: _____			NP#:	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: <input type="checkbox"/> Male <input type="checkbox"/> 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®	<input type="checkbox"/> Take 1 tablet (150mg) by mouth once daily.	<input type="checkbox"/> 28	<input type="checkbox"/> 150mg tablets	_____
	<input type="checkbox"/> Take 1 tablet (200mg) by mouth twice daily.	<input type="checkbox"/> 56	<input type="checkbox"/> 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