HOME PARENTERAL SERVICES

Springfield
2240 W. Sunset, Ste. 104
Springfield, MO 65807

Cape Girardeau
113 S. Silver Springs Rd.,Ste. 101
Cape Girardeau, MO 63703

PHONE: **1-800-637-9201**
FAX: **1-417-269-0692**

WOMEN'S HEALTHCARE FORM

Start Date _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: ____ /____ / ____ ☐ 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
☐ LUPANETA PACK	☐ LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 3.75 MG INJECTION IM Monthly+ NORETHINDRONE 5 MG TABLETS, ONE TABLET BY MOUTH DAILY * DISCLAIMER LUPRON 3.75 MG + 3O NORETHINDRONE ACETATE 5MG TO BE FILLED UPON DENIAL	#1 - 3.75mg PFS and #30 tablets		
	☐ LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 11.25 MG INJECTION IM Q 3 MONTHS + NORETHINDRONE 5 MG TABLETS, ONE TABLET BY MOUTH DAILY * DISCLAIMER LUPRON 11.25 MG + 90 NORETHINDRONE ACETATE 5MG TO BE FILLED UPON DENIAL	#1 - 11.25g PFS and #90 tablets		
☐ LUPRON DEPOT	☐ LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 3.75 MG INJECTION IM Monthly	#1 - 3.75mg PFS		
	☐ LEUPROLIDE ACETATE FOR DEPOT SUSPENSION 11.25 MG INJECTION IM Q 3 MONTHS	#1 - 11.25mg PFS		
☐ ORILISSA	☐ Take 150mg by mouth daily	#28 - 150mg tablets		
	☐ Take 200mg by mouth twice daily	#56 - 200mg tablets		

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

Directions: _____

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

May Substitute Dispense as Written

, I authorize Home Parenteral Services 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 ☐ HPS RN Date Shipment Needed By: ____ /____ / ____

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