Across Specialty Pharmacy

OBGYN & Weight Loss Drugs(Injectable) REFERRAL FORM

PH (770) 746 0130 | **FAX** (770) 746 0131
NCPDP 1175288 | **NPI** 1275142614

First Dose Given By: ☐ Provider/Clinic ☐ Patient ☐ Home Health Date Shipment Needed:

PATIENT INFORMATION

Patient Name:				Prescriber:			
Street Address:				NPI:		Specialty:	☐ Endocrinologist/wt loss ☐ Other _____
City, State, Zip:				Street Address:			
Phone #1:		Phone #2:		City, State, Zip:			
Height: _____	Weight: _____	Sex:	☐ Male ☐Female	Office Phone:		Office Fax:	
Date of Birth:		Allergies:		Primary Contact:			
Comorbidities:				Email:			

DOCTOR INFORMATION

INJECTION TRAINING: ☐ **Office** ☐ **Specialty Pharmacy**

CLINICAL INFORMATION

New Therapy ☐ Renewal Therapy: If Renewal, Date Therapy Initiated:_____

Diagnosis ICD 10:_____**Other:** _____

☐ Pediatrics patient with weight 60kg or above☐Yes☐No
☐ Does patient have diagnosis of DIABETES? ☐Yes ☐No
☐ Does a patient have diagnosis of OSTEPOROSIS/BONELOSS ? ☐ Yes ☐ No

Does the patient have BMI ≥ 30KG/M² ☐ Yes☐No. BMI:_____
Does the patient have any co-morbid condition ☐Yes ☐ No
Does the patient have/family history of Medullary Thyroid Carcinoma (MTC) ☐Yes ☐No
Other:_____

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Dose Directions	Refills
BIRTH CONTROL			
☐ Annovera	☐ Ring	☐ Insert 1 vaginal ring system intravaginaly in place continuously for 3 weeks (21 days) followed by a 1-week (7-day) vaginal system-free interval. Re-insert a ring after 1 week system-free interval period. Qty:_____	Refill:
☐ Balcotra	☐ Pak	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
☐ Lo Loestrin FE	☐ Pak	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
☐ Nextstellis	☐ Pak	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
☐ Phexxi	☐ Box	☐ Insert 1 application intravaginaly right before or up to 1 hr prior to vaginal intercourse Qty:_____	Refill:
☐ Slynd	☐ Box	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
BV			
☐ Nuvessa	☐ Box	☐ Apply 1 applicatorful PV at bed time Qty:_____	Refill:
☐ Solosec	☐ Box	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
MENOPAUSE			
☐ Bijuva	☐ Box	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
☐ Imvexy	☐ 12 mcg ☐ 4 mcg	☐ Insert 1 suppository per vagina once daily for 2 weeks	Refill:
☐ Intrarosa	☐ Box	☐ Insert 1 suppository inragavaginaly at bedtime Qty:_____	Refill:
MIGRAINE			
☐ UBRELVY	☐ 100 mg ☐ 50 mg	☐ Take 1 tablet by mouth Qty:_____	Refill:
☐ NURTEC	☐ Pak	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
☐ QUILIPTA	☐ 10 mg ☐ 30 mg ☐ 60 mg	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:
☐ AIMOVIG	☐ 140 mg PFS ☐ 75 mg-ML	☐ Inject 1 pen subcutaneously every month Qty:_____	Refill:
☐ EMGALITY	☐ 100 mg ☐ 120 mg	☐ Inject___mg subcutaneously every_____days Qty:_____	Refill:
ENDOMETRIOSIS			
☐ Orilissa	☐ 150 mg ☐ 200 mg	☐ Take 1 tablet by mouth once a day Qty:_____	Refill:
FIBROIDS(UTERINE)			
☐ ORIAHNN	☐ Pak	☐ Take 1 tablet by mouth once a day Qty:_____	Refill:
☐ LUPRON	☐ Pak		Refill:
CANDIDIASIS			
☐ Brexafemme	☐ 150 Mg tabs	☐ Take tablet in the morning and tablet in the evening with/without food Qty:_____	Refill:
WEIGHT LOSS			
☐ Saxenda®	☐ Prefilled Syringe	☐ **Induction**: Inject 0.6mg per day for 1 week and increase the dose until dose of 3mg is reached ☐ **Maintenance**: Inject 3mg/0.5ml SQ daily ☐ **Pediatric**: mg SQ every Qty:_____	Refill:
☐ Wegovy ® (Pen)	☐ 0.25mg / 0.5ml ☐ 0.5mg / 0.5ml ☐ 1mg / 0.5ml	☐ **Initial**: Inject ☐ 0.25mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 1-4) Start date:_____ ☐ 0.5mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 5-8)	Refill:

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	☐ 1.7mg / 0.5ml ☐ 2.4mg / 0.5ml	☐ 1mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 9-12) ☐ 1.7mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 13-16) ☐ 2.4mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 17-20) ☐ **Maintenance:** Inject 2.4mg / 0.5ml SQ once a week thereafter Qty:___box	
DIABETES			
☐ MOUNJARO	☐ 2.5mg / 0.5ml ☐ 5 mg / 0.5ml ☐ 7 mg / 0.5ml ☐ 10 mg / 0.5ml ☐ 12.5mg / 0.5ml ☐ 15 mg / 0.5ml	☐ **Initial:** Inject ☐ 2.5mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 1-4) Start date:_____ ☐ 5mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 5-8) ☐ 10mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 9-12) ☐ 12.5mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 13-16) ☐ 15mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 17-20) Qty:____box	Refill:
☐ OZEMPIC	☐ 0.25mg / 0.5ml ☐ 0.5mg / 0.5ml ☐ 1mg / 0.5ml ☐ 2mg / 0.5ml	☐ **Initial**: Inject ☐ 0.25mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 1-4) Start date:_____ ☐ 0.5mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 5-8) ☐ 1mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 9-12) ☐ 2mg / 0.5ml SQ once weekly for 4 weeks (WEEKS 13-16) ☐ **Maintenance**: Inject 2 mg / 0.5ml SQ once a week thereafter Qty:___box	Refill:
MISC PRODUCTS			
☐ ADDYI	☐ Tab	☐ Take 1 tablet by mouth everyday Qty:_____	Refill:

OTHER:	**STRENGTH:**	**SIG/DIRECTIONS:**	**QUANTITY:**	**REFILL**

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature _____ Date _____ Supervising Physician Signature (where required by state law) _____ Date _____

DAW (Dispense as Written) _____ Date _____ Brand Necessary (must handwrite) _____