PHARMACA®
SPECIALTY PHARMACY

SEXUAL HEALTH ENROLLMENT FORM

Fax: **888.882.3341**
Call: **855.465.8892**

1 PATIENT INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: _____ Zip: ________
Phone: ____________ Alt Phone: ____________
Email: ______________________
DOB: __________ ☐ M ☐ F Last 4 of SSN: ________

2 PRESCRIBER INFORMATION:

Name: ______________________
Address: ______________________
City: ____________ State: _____ Zip: ________
Phone: ____________ Fax: ____________
NPI: ____________ DEA: ____________
Office Contact: ____________ Phone: ____________

3 INSURANCE INFORMATION:

Please attach front and back copies of prescription/medical insurance card(s).

4 CLINICAL INFORMATION:

To expedite prior authorization, please attach relevant clinical documentation.

Primary ICD-10: __________ Drug Allergies: ☐ NKDA ☐ ______________________

If prior authorization is denied, preferred alternatives or the option to appeal, if available, will be provided to the office.

Additional Information: ______________________

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5 INJECTION TRAINING:

☐ Physician to Train ☐ Pharmacist to Train ☐ Other: ____________

6 PRODUCT DELIVERY:

☐ Physician's Office ☐ Patient's Home ☐ Other: ____________

PRESCRIPTION INFORMATION:

Medication	Dose and Form	Directions	Qty	Refills
☐ **Addyi**	☐ 100 mg Tablets	☐ Take one tablet by mouth once daily at bedtime		
☐ **Annovera**	☐ Vaginal System	☐ Insert one ANNOVERA vaginally. The vaginal system must remain in place continuously for 3 weeks followed by a 1-week vaginal system-free interval.	1	0
☐ **Bijuva**	☐ 1 mg/100 mg Tablets	☐ Take one capsule by mouth every evening with food		
☐ **Edex**	☐ 10 mcg Cartridge Pack ☐ 20 mcg Cartridge Pack ☐ 40 mcg Cartridge Pack	☐ Administer intracavernous injection as instructed by your physician no more than 3 times weekly with at least 24 hours between doses		
☐ **Imvexxy**	☐ 4 mcg Vaginal Insert ☐ 10 mcg Vaginal Insert	☐ **Induction:** Insert one daily at approximately the same time for 2 weeks, then insert one twice weekly for maintenance	18	
		☐ **Maintenance:** Insert one twice weekly every 3-4 days (ex. Mon and Thurs)	8	
☐ **Orilissa**	☐ 150 mg Tablets ☐ 200 mg Tablets	☐ Take one tablet by mouth once daily ☐ Take one tablet by mouth twice daily		
☐ **Pregnyl**	☐ 10,000 USP Units Multidose Vial	☐ Inject ________ USP units IM 1 day following the last dose of menotropins		
☐ **Xiaflex**	☐ 0.9 mg Single-use Vial	☐ Inject ________ mL as instructed by your physician		
☐ **Xyosted**	☐ 50 mg/0.5 mL Autoinjector ☐ 75 mg/0.5 mL Autoinjector ☐ 100 mg/0.5 mL Autoinjector	☐ Inject 75 mg SC in the abdominal region once weekly		
☐				

I authorize Pharmaca and its affiliates to act on my behalf to obtain prior authorization and/or other assistance if applicable. I acknowledge that prior authorization/payment is not guaranteed.

PHYSICIAN SIGNATURE REQUIRED

X ______________________ Substitution Permitted ______ Date

X ______________________ Dispense as Written ______ Date

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