

Fertility Referral Form

TODAY'S DATE: _____
<input type="checkbox"/> NEW START <input type="checkbox"/> CONTINUATION OF THERAPY
SHIP TO: <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> KERR DRUG STORE: _____
DATE SHIPMENT NEEDED: _____

GENERAL INFORMATION

PATIENT (FIRST NAME, LAST NAME): _____		ADDRESS: _____	
CITY: _____	STATE: _____	ZIP: _____	DOB: _____
SS#: _____	HOME#: _____	CELL#: _____	WORK#: _____
ALLERGIES: _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT: _____	WEIGHT: _____
CURRENT MEDS: _____			
PHYSICIAN NAME: _____		PRACTICE NAME/HOSPITAL: _____	
ADDRESS: _____	CITY: _____	STATE: _____	ZIP: _____
PHONE#: _____	FAX#: _____	STATE LIC#: _____	DEA#: _____
NURSE/KEY OFFICE CONTACT: _____		NPI#: _____	

INSURANCE INFORMATION

PRIMARY INSURANCE:		EMPLOYER: _____	
CARDHOLDER NAME: _____	ID#: _____	GROUP#: _____	PHONE#: _____
SECONDARY INSURANCE:	ID#: _____	GROUP#: _____	PHONE#: _____

STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS: _____	DATE: _____
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PRESCRIPTION INFORMATION

<h4>GONADOTROPINS</h4> <p><input type="checkbox"/> Bravelle® <input type="checkbox"/> Menopur® <input type="checkbox"/> Repronex® <input type="checkbox"/> 75 IU w/Qcap™ <input type="checkbox"/> SubQ <input type="checkbox"/> IM Qty: _____ Sig: _____ Refills: _____ # _____ 3 cc 18 g 1^{1/2}" syringes/needles # _____ 25 g 1^{1/2}" needles</p> <p><input type="checkbox"/> Follistim® AQ (Vial) <input type="checkbox"/> 75 IU <input type="checkbox"/> 150 IU Qty: _____ Sig: _____ Refills: _____ # _____ 3 cc 18 g 1^{1/2}" syringes/needles # _____ 25 g 1^{1/2}" needles</p> <p><input type="checkbox"/> Follistim® AQ (Cartridge) <input type="checkbox"/> 300 IU <input type="checkbox"/> 600 IU <input type="checkbox"/> 900 IU <input type="checkbox"/> Follistim® Pen Needles # _____ Qty: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Gonad-f® (Vial) <input type="checkbox"/> 450 IU <input type="checkbox"/> 1050 IU Qty: _____ Sig: _____ Refills: _____ # _____ 3 cc 18 g 1^{1/2}" syringes/needles # _____ 25 g 1^{1/2}" needles</p> <p><input type="checkbox"/> Gonad-f® RFF Pen <input type="checkbox"/> 300 IU <input type="checkbox"/> 450 IU <input type="checkbox"/> 900 IU Qty: _____ Sig: _____ Refills: _____</p>	<h4>GnRH ANTAGONISTS</h4> <p><input type="checkbox"/> Ganirelix Acetate 250 mcg pre-filled syringe Sig: _____ Qty: _____ Refills: _____</p> <p><input type="checkbox"/> Cetrotide® 0.25 mg vials Sig: _____ Qty: _____ Refills: _____</p>	<h4>SUPPORTIVE MEDICATIONS</h4> <p><input type="checkbox"/> Aspirin _____ mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Heparin _____ units Qty: _____ Refills: _____ Sig: _____ <input type="checkbox"/> 27 g 1/2" needles # _____ <input type="checkbox"/> 1 cc syringe # _____</p> <p><input type="checkbox"/> Femara® 2.5 mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Diazepam _____ mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Dexamethasone _____ mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Methylprednisolone _____ mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Metformin _____ mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Doxycycline _____ mg Qty: _____ Refills: _____ Sig: _____</p> <p><input type="checkbox"/> Prenatal Vitamins 1 tab PO Qday Qty: _____ Refills: _____</p>
<h4>HUMAN CHORIONIC GONADOTROPINS</h4> <p><input type="checkbox"/> Novarel® <input type="checkbox"/> Pregnyl® <input type="checkbox"/> hCG 10,000 units Qty: _____ Sig: _____ Refills: _____ <input type="checkbox"/> 3 cc syringes 22 g 1^{1/2}" needles # _____ <input type="checkbox"/> 25 g 1^{1/2}" needles # _____</p> <p><input type="checkbox"/> Ovidrel® 250 mcg pre-filled syringe Qty: _____ <input type="checkbox"/> Ovidrel® Microdose Vials 25 mcg/mL (2 mL volume) Qty: _____ Sig: _____ Refills: _____ <input type="checkbox"/> 3 cc syringes 22 g 1^{1/2}" needles # _____ <input type="checkbox"/> 25 g 1^{1/2}" needles # _____ Refills: _____</p>	<h4>PROGESTERONE</h4> <p><input type="checkbox"/> Oral Capsules <input type="checkbox"/> 100 mg <input type="checkbox"/> 200 mg <input type="checkbox"/> Crinone® 8% gel</p> <p><input type="checkbox"/> Progesterone in Ethyl Oleate 50 mg/mL <input type="checkbox"/> Qday <input type="checkbox"/> BID <input type="checkbox"/> 3 cc syringes 18 g 1^{1/2}" needles # _____ <input type="checkbox"/> 22 g 1^{1/2}" needle # _____ _____ mg Sig: _____ x _____ Days Qty: _____ Refills: _____</p>	<h4>ORAL CONTRACEPTIVES</h4> <p><input type="checkbox"/> Product _____ Qty: _____ Sig: _____ Refills: _____</p>
<h4>GnRH AGONISTS</h4> <p><input type="checkbox"/> Lupron® 5 mg/mL 14 day kit Qty: _____ Sig: _____ Refills: _____</p>	<h4>ESTROGEN PRODUCTS</h4> <p><input type="checkbox"/> Estrace® 2 mg _____ Qty: _____ Sig: _____ Refills: _____</p> <p><input type="checkbox"/> Delestrogen <input type="checkbox"/> 10 mg/mL <input type="checkbox"/> 20 mg/mL <input type="checkbox"/> 40 mg/mL Sig: _____ Qty: _____ 3 cc syringes # _____ 25 g 1^{1/2}" needles # _____ Refills: _____</p>	<h4>EXTRAS</h4> <p>Syringes <input type="checkbox"/> 1 cc <input type="checkbox"/> 3 cc Qty: _____ Refills: _____</p> <p>Needles <input type="checkbox"/> 18 g <input type="checkbox"/> 21 g <input type="checkbox"/> 22 g <input type="checkbox"/> 25 g <input type="checkbox"/> 27 g Qty: _____ Refills: _____</p>

Ancillary supplies and kits provided as needed for administration.

* If you would like brand name, please write "Brand Medically Necessary". Please note that Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.

* I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Physician Signature: _____ Date: _____

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