

FERTILITY REFERRAL FORM

PHONE: 877.RxHyVee (877.794.9833)
FAX: 855.861.4941

Patient Information			PLEASE FAX INSURANCE CARD (FRONT AND BACK)			Prescriber Information			
Last Name		First Name	DOB			Practice/Facility Name			
Address						Address			
City		State	ZIP		City		State	ZIP	
Phone			SSN			Prescriber Name			
Allergies Latex Allergy Yes No						Prescriber NPI			
Sex	Male	Female	Weight (kg)		Height (ft,in)		Nurse/Key Contact		
Insurance Plan		Plan ID #				Fax		Email	

Clinical Information							
PLEASE FAX CLINICAL AND LAB INFORMATION							
CYRO/AH	CRYO CYCLE	IVF	ISCI/AH	RECIPIENT (Egg Donation)	EGG DONOR	IUI (Partner)	IUI (Donor)

Prescription Information			
Cetrotide® 0.25mg Sig: _____ Ganirelix Acetate® 250mcg/0.5ml Sig: _____	___ Quantity ___ Refills ___ Quantity ___ Refills	Progesterone Capsules 100mg 200mg Sig: _____ Progesterone in Oil 50mg/ml 10ml vial Sig: _____ 18G 1 1/2" needle 3cc syringe/22G 1 1/2" needle	___ Quantity ___ Refills ___ # ___ Refills ___ # ___ Refills
Leuprolide Acetate 2 Week Kit Sig: _____ 1/2cc 30G 1/2" insulin syringe Lupron Depot® 3.75mg Sig: _____	___ Quantity ___ Refills ___ # ___ Refills ___ Quantity ___ Refills	Estradiol Tablets 0.5mg 1mg 2mg Sig: _____ Estradiol Patch 0.025mg .05mg 0.1mg Sig: _____ Vivelle Dot® Patch 0.025mg 0.05mg 0.1mg Sig: _____	___ Quantity ___ Refills ___ Quantity ___ Refills ___ Quantity ___ Refills
Gonal-f® RFF Redi-ject™ 300IU Gonal-f® RFF Redi-ject™ 450IU Gonal-f® RFF Redi-ject™ 900IU Sig: _____	___ Each ___ Refills ___ Each ___ Refills ___ Each ___ Refills	Crinone® 8% Gel Applicators Sig: _____ Endometrin® Vaginal Inserts 100mg Sig: _____ Medroxyprogesterone Tablets 2.5mg 5mg 10mg Sig: _____	___ Quantity ___ Refills ___ Quantity ___ Refills ___ Quantity ___ Refills
Gonal-f® Multi-Dose 450IU Gonal-f® Multi-Dose 1050IU Sig: _____	___ Quantity ___ Quantity ___ Refills	Clomiphene Citrate Tablets 50mg Sig: _____	___ Quantity ___ Refills
Follistim AQ® 300IU Cartridge Follistim AQ® 600IU Cartridge Follistim AQ® 900IU Cartridge Sig: _____ Follistim Pen	___ Each ___ Refills ___ Each ___ Refills ___ Each ___ Refills	Doxycycline Capsules/Tablets 100mg Sig: _____ Methylprednisolone Tablets 4mg 8mg 16mg Sig: _____ Azithromycin Tablets 250mg Sig: _____	___ Quantity ___ Refills ___ Quantity ___ Refills ___ Quantity ___ Refills
Menopur® 75IU Vial Sig: _____ 27G 1/2" needle 3cc syringe/22G 1 1/2" needle	___ Quantity ___ Refills ___ # ___ Refills ___ # ___ Refills	Other Sig: _____ Other Sig: _____	___ Quantity ___ Refills ___ Quantity ___ Refills
Ovidrel® 250mcg Sig: _____ Novarel® 10,000IU Vial Sig: _____ Pregnyl® 10,000IU Vial Sig: _____ 25G 1 1/2" needle 3cc syringe/22G 1 1/2" needle	___ Quantity ___ Refills ___ Quantity ___ Refills		___ Quantity ___ Refills

Additional Supplies Needed: Sharps container Alcohol wipes (Qty _____)

DATE NEEDED _____ *Please attach copy of dosing calendar if available

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____ DISPENSE AS WRITTEN/Do Not Substitute (date) _____

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