FERTILITY REFERRAL FORM

PHONE: 877.RxHyVee (877.794.9833)
FAX: 855.861.4941

Hy-Vee Pharmacy SOLUTIONS

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
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:_____
____ Quantity
____ Refills

☐ **Ganirelix Acetate®** 250mcg/0.5ml
Sig:_____
____ Quantity
____ Refills

☐ **Leuprolide Acetate** 2 Week Kit
Sig:_____
____ Quantity
____ Refills
☐ 1/2cc 30G ½" insulin syringe
_____# _____ Refills

☐ **Lupron Depot®** 3.75mg
Sig:_____
____ 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

☐ **Gonal-f® Multi-Dose** 450IU
☐ **Gonal-f® Multi-Dose** 1050IU
Sig:_____
____ Quantity
____ Quantity
____ Refills

☐ **Follistim AQ®** 300IU Cartridge
☐ **Follistim AQ®** 600IU Cartridge
☐ **Follistim AQ®** 900IU Cartridge
Sig:_____
☐ Follistim Pen
____ Each _____Refills
____ Each _____Refills
____ Each _____Refills

☐ **Menopur®** 75IU Vial
Sig:_____
☐ 27G ½" needle
☐ 3cc syringe/22G 1 ½" needle
____ Quantity
____ Refills
_____# _____ Refills
_____# _____ Refills

☐ **Ovidrel®** 250mcg
Sig:_____
____ Quantity
____ Refills

☐ **Novarel®** 10,000IU Vial
Sig:_____
____ Quantity
____ Refills

☐ **Pregnyl®** 10,000IU Vial
Sig:_____
☐ 25G 1 ½" needle
☐ 3cc syringe/22G 1 ½" needle

☐ **Progesterone Capsules** ☐100mg ☐200mg
Sig:_____
____ Quantity
____ Refills

☐ **Progesterone in Oil** 50mg/ml 10ml vial
Sig:_____
☐ 18G 1 ½" needle
☐ 3cc syringe/22G 1 ½ needle
____ Quantity
____ Refills
_____# _____ Refills
_____# _____ Refills

☐ **Estradiol Tablets** ☐ 0.5mg ☐ 1mg ☐ 2mg
Sig:_____
____ Quantity
____ Refills

☐ **Estradiol Patch** ☐ 0.025mg ☐.05mg ☐0.1mg
Sig:_____
____ Quantity
____ Refills

☐ **Vivelle Dot® Patch** ☐ 0.025mg ☐ 0.05mg ☐ 0.1mg
Sig:_____
____ Quantity
____ Refills

☐ **Crinone® 8% Gel** Applicators
Sig:_____
____ Quantity
____ Refills

☐ **Endometrin® Vaginal Inserts** 100mg
Sig:_____
____ Quantity
____ Refills

☐ **Medroxyprogesterone Tablets** ☐ 2.5mg ☐ 5mg ☐ 10mg
Sig:_____
____ Quantity
____ Refills

☐ **Clomiphene Citrate Tablets** 50mg
Sig:_____
____ Quantity
____ Refills

☐ **Doxycycline Capsules/Tablets** 100mg
Sig:_____
____ Quantity
____ Refills

☐ **Methylprednisolone Tablets** ☐ 4mg ☐ 8mg ☐ 16mg
Sig:_____
____ Quantity
____ Refills

☐ **Azithromycin Tablets** 250mg
Sig:_____
____ Quantity
____ Refills

☐ **Other**
Sig:_____
____ Quantity
____ Refills

☐ **Other**
Sig:_____
____ 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)