PREMIER
PHARMACY SERVICES

Fax: 800.540.3400
Phone: 800.540.4700

To ePrescribe, send prescription to:
Premier Pharmacy Services
410 Cloverleaf Drive
Baldwin Park, CA 91706

FERTILITY
REFERRAL FORM

Ship to: ☐ Patient ☐ Physician ☐ Other **Need:** ☐ Nurse ☐ Training
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Patient Name: _____ DOB: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alt Phone: _____

Alternate Contact Name: _____ Alt Contact Phone: _____

Gender: ☐ Male ☐ Female E-Mail: _____

PLEASE ATTACH COPIES OF FRONT AND BACK OF PATIENT'S PRESCRIPTION INSURANCE CARDS AND MOST RECENT LABS

Clinical Information

Patient Therapy Status: ☐ Naïve/New Start ☐ Therapy Restart ☐ Existing Treatment	Last Treatment Date: _____	Therapy Start Date: _____
Other/Concomitant Medications (please list): _____ _____	Height: _____ Weight: _____ Date obtained: _____	
Allergies: ☐ NKDA ☐ Drug allergies (please list): _____		
Check all that apply: ☐ CRYO/AH ☐ CRYO CYCLE ☐ IVF ☐ ISCI/AH ☐ RECIPIENT (Egg Donation) ☐ EGG DONOR ☐ IUI (Partner) ☐ IUI (Donor)		
Diagnosis: ICD-10 Code: _____ Description: _____		

Prescription Information

Please e prescribe if required by State law. For brand name product to be dispensed, the prescriber must handwrite Brand Necessary" or Brand Medically Necessary" or your state specific required language to prohibit substitutions.

Medication	Sig / Directions	Quantity	Refills
☐ **Cetrotide®** 0.25mg	Sig / Directions: _____	_____ Kits	_____
☐ **Clomiphene Citrate** 50mg	Sig / Directions: _____	_____ Tabs	_____
☐ **Crinone** 8% Vaginal Gel Applicator	Sig / Directions: _____	_____ QTY	_____
☐ **Endometrin Vaginal Inserts** 100mg ak-21	Sig / Directions: _____	_____ QTY	_____
☐ **Follistim AQ** 300IU Cartridge ☐ **Follistim AQ** 600IU Cartridge ☐ **Follistim AQ** 900IU Cartridge	Sig / Directions: _____	_____ QTY	_____
☐ **Follistim Pen**	Sig / Directions: _____	_____ Pens	_____
☐ **Ganirelix Acetate** 250mcg/0.5ml PFS	Sig / Directions: _____	_____ PFS	_____
☐ **Gonal-f® RFF Redi-ject** 300IU ☐ **Gonal-f® RFF Redi-ject** 450IU ☐ **Gonal-f® RFF Redi-ject** 900IU	Sig / Directions: _____	_____ Pens	_____
☐ **Gonal-f® Multi-Dose** 450IU ☐ **Gonal-f® Multi-Dose** 1050IU	Sig / Directions: _____	_____ Vials	_____
☐ **Leuprolide Acetate** 2 Week Kit ☐ ½ CC 30G ½ insulin syringe	Sig / Directions: _____	_____ Kits _____ QTY	_____ _____
☐ **Leuprolide Acetate**	Sig / Directions: _____	_____ Kits	_____
☐ **Lupron Depot** 3.75mg	Sig / Directions: _____	_____ Kits	_____

Referral form continued on next page

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Medication	Sig / Directions	Quantity	Refills
☐ **Medroxyprogesterone** ☐ 2.5mg ☐ 5mg ☐ 10mg ☐ **Depo-Provera** IM Suspension ☐ 150mg/ml vial ☐ 150mg PFS ☐ **Depo-subQ Provera** 104mg/0.65ml PFS	Sig / Directions: _____ Sig / Directions: _____ Sig / Directions: _____	_____ Tabs _____ Vials/PFS _____ QTY	_____ _____ _____
☐ **Menopur®** 75IU Vial ☐ 27G ½" Needle ☐ 3CC Syringe	Sig / Directions: _____	_____ Kits _____ QTY _____ QTY	_____ _____ _____
☐ **Metformin** ☐ 500mg ☐ 625mg ☐ 850mg ☐ 1000mg	Sig / Directions: _____	_____ Tabs	_____
☐ **Novarel** 5,000IU ☐ 25G ⅝" 3CC Syringe and Needle ☐ 10ml Syringe ☐ 3ml Syringe ☐ 21G 1 ½ "needle	Sig / Directions: _____	_____ Vials _____ QTY _____ QTY _____ QTY _____ QTY	_____ _____ _____ _____ _____
☐ **Ovidrel** 250mcg PFS	Sig / Directions: _____	_____ PFS	_____
☐ **Pregnyl** 10,000IU ☐ 25G ⅝" 3CC Syringe and Needle ☐ 10ml Syringe ☐ 3ml Syringe ☐ 21G 1 ½ "needle	Sig / Directions: _____	_____ Vials _____ QTY _____ QTY _____ QTY _____ QTY	_____ _____ _____ _____ _____
☐ **Progesterone** in Sesame Oil 50mg/ml ☐ 18G 1½" 3CC Syringe and Needle ☐ 22G 1½" Needle	Sig / Directions: _____	_____ 10ml multidose vials _____ QTY _____ QTY	_____ _____ _____
☐ **Progesterone** ☐ 100mg ☐ 200mg	Sig / Directions: _____	_____ Caps	_____

Additional Supplies

☐ Sharps Package: Sharps disposal unit, alcohol wipes, gauze, disposal instructions, etc.

☐ 22G 1 ½" 3CC syringe and needle QTY: _____RF: _____

☐ 18G 1 ½" 3CC syringe and needle QTY: _____RF: _____

☐ 25G ⅝" needle QTY: _____RF: _____

☐ 20G 1 ½" filter needle QTY: _____RF: _____

Prescriber Information

PRIOR AUTHORIZATION

Prescriber Name: _____ NPI: _____ DEA: _____ LIC#: _____

Address: _____

City: _____ Zip: _____ Tel: _____ Fax: _____

Contact Person: _____ E-Mail: _____

PRESCRIBER SIGNATURE
(Prescriber, please sign and date below)

No stamps. Signature and date must be completed in prescriber s handwriting.
NY prescriptions must be submitted via e script.

I authorize Premier Pharmacy and its representatives to act as an agent to initiate and execute prior authorization for the above patient in order to expedite the process, please provide chart notes and most recent labs.

Physician's Signature: _____ ☐ **Dispense as written (DAW) Date:** _____/_____/_____