Blue Cross Blue Shield of Montana
Live Smart. Live Healthy.®

PRIME THERAPEUTICS
SPECIALTY PHARMACY™

FAMILY PLANNING REFERRAL FORM

SIGN AND FAX THIS FORM TO 877.828.3939
If you have questions, please call 877.627.MEDS (6337)

PATIENT/PRESCRIBER

PATIENT INFORMATION	PRESCRIBER INFORMATION
First name: Last name: DOB:	Office name:
Address:	Address:
City/State/Zip	City/State/Zip:
Primary phone:	Phone: Fax:

PRESCRIPTION INFORMATION

ICD-9: _____ **Cycle #:** _____ **Cycle Type:** ☐ IVF ☐ IUI ☐ FET ☐ **Provide copy of front and back of ins. card**

☐ Leuprolide Acetate 1 mg / 0.2ml (2 week kit) _____qty (kits)
Sig: _____(= _____days) _____refills

☐ Microdose Leuprolide Acetate _____mcg/ _____ml 5 ml vial
Sig: _____(= _____days) _____qty
☐ ½ cc insulin syringes _____qty _____refills

☐ Ganirelix Acetate injection 250 mcg _____qty
Sig: _____(= _____days) _____refills

☐ Cetrotide ☐ 0.25 mg ☐ 3 mg _____qty
Sig: _____(= _____days) _____refills

☐ Follistim AQ Cartridge ☐ Follistim pen
☐ 300 ☐ 600 ☐ 900 IU _____qty
Sig: _____(= _____days) _____refills
☐ Follistim AQ 75 IU _____qty (vials)
☐ Follistim AQ 150 IU _____qty (vials)
Sig: _____(= _____days) _____refills
☐ 3cc 22G 1 ½" syringe/needles # _____ _____g _____" needles

☐ Gonal-f RFF Pen ☐ 300 ☐ 450 ☐ 900 IU _____qty
Sig: _____(= _____days) _____refills
☐ Gonal-f 450 IU multidose _____qty (vials)
☐ Gonal-f 1050 IU multidose _____qty (vials)
☐ Gonal-f RFF 75 IU _____qty (vials)
Sig: _____(= _____days) _____refills

☐ Repronex 75 IU ☐ Menopur 75 IU
☐ IM SC _____qty (vials)
Sig: _____(= _____days) _____refills
☐ 3cc 22G 1 ½" syringe/needles # _____ _____g _____" needles

☐ Bravelle75 IU ☐ IM ☐ SC _____qty (vials)
Sig: _____(= _____days) _____refills
☐ 3cc 22G 1 ½" syringe/needles # _____ _____g _____" needles

☐ Luveris 75 IU ☐ IM ☐ SC _____qty (vials)
Sig: _____(= _____days) _____refills
☐ 3cc 22G 1 ½" syringe/needles # _____ _____g _____" needles

☐ HCG 10,000 IU ☐ Novarel 10,000 IU ☐ Pregnyl 10,000 IU
Sig: _____ (= _____days) _____qty _____refills
☐ 3cc 22G 1 ½" syringe/needles # _____ _____g _____" needles

☐ Low Dose HCG ☐ 10 IU/mL ☐ 20 IU/mL _____qty
Sig: _____ (= _____days) _____refills
☐ 1 cc insulin syringes _____qty

☐ Ovidrel 250 mcg prefilled syringes _____qty
Sig: _____ (= _____days) _____refills

☐ Crinone 8% gel – 15 per box _____qty
Sig: _____ (= _____days) _____refills

☐ Progesterone in sesame oil 50 mg/ml 10 ml vial _____ qty
☐ Progesterone in ethyl oleate 50 mg/ml 10 ml vial _____ qty
☐ Progesterone suppositories _____ mg _____ qty
Sig: _____ (= _____days) _____ refills
☐ Draw: 3cc 18G 1½" syringe/needles _____ qty
☐ Inject: 22G 1½" needles _____ qty

☐ Endometrin vaginal tablet 100 mg _____qty
Sig: _____ (= _____days) _____refills

☐ Prometrium 200 mg capsules _____qty
Sig: _____ (= _____days) _____refills

☐ Medrol _____mg tablets _____qty
Sig: _____ (= _____days) _____refills

☐ Doxycycline 100 mg capsules _____qty
Sig: _____ (= _____days) _____refills

☐ Clomid 50 mg _____qty
Sig: _____ (= _____days) _____refills

☐ Estrace ☐ 1 mg ☐ 2mg tablets _____qty
Sig: _____ (= _____days) _____refills

☐ Estrace patch _____mg ☐ Vivelle dot ____mg _____qty
Sig: _____ (= _____days) _____refills

☐ Desogen ☐ Mircette _____qty
Sig: _____ (= _____days) _____refills

☐ Other: _____ qty
Sig: _____ (= _____days) _____refills

☐ Other: _____qty
Sig: _____ (= _____days) _____refills

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

☐ **Dispense as written/Do not substitute** **Date**

☐ **Substitution permitted/Brand exchange permitted** **Date**

For states requiring hand written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).

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