

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: <input type="checkbox"/> IVF <input type="checkbox"/> IUI <input type="checkbox"/> FET <input type="checkbox"/> Provide copy of front and back of ins. card	
	<input type="checkbox"/> Leuprolide Acetate 1 mg / 0.2ml (2 week kit) _____ qty (kits) Sig: _____ (= _____ days) _____ refills	<input type="checkbox"/> Low Dose HCG <input type="checkbox"/> 10 IU/mL <input type="checkbox"/> 20 IU/mL _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> 1 cc insulin syringes _____ qty
	<input type="checkbox"/> Microdose Leuprolide Acetate _____ mcg/ _____ ml 5 ml vial Sig: _____ (= _____ days) _____ qty <input type="checkbox"/> ½ cc insulin syringes _____ qty _____ refills	<input type="checkbox"/> Ovidrel 250 mcg prefilled syringes _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> Ganirelix Acetate injection 250 mcg _____ qty Sig: _____ (= _____ days) _____ refills	<input type="checkbox"/> Crinone 8% gel – 15 per box _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> Cetrotide <input type="checkbox"/> 0.25 mg <input type="checkbox"/> 3 mg _____ qty Sig: _____ (= _____ days) _____ refills	<input type="checkbox"/> Progesterone in sesame oil 50 mg/ml 10 ml vial _____ qty <input type="checkbox"/> Progesterone in ethyl oleate 50 mg/ml 10 ml vial _____ qty <input type="checkbox"/> Progesterone suppositories _____ mg _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> Follistim AQ Cartridge <input type="checkbox"/> Follistim pen <input type="checkbox"/> 300 <input type="checkbox"/> 600 <input type="checkbox"/> 900 IU _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> Follistim AQ 75 IU _____ qty (vials) <input type="checkbox"/> Follistim AQ 150 IU _____ qty (vials) Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> 3cc 22G 1 ½" syringe/needles # _____ g _____ " needles	<input type="checkbox"/> Draw: 3cc 18G 1½" syringe/needles _____ qty <input type="checkbox"/> Inject: 22G 1½" needles _____ qty
	<input type="checkbox"/> Gonal-f RFF Pen <input type="checkbox"/> 300 <input type="checkbox"/> 450 <input type="checkbox"/> 900 IU _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> Gonal-f 450 IU multidose _____ qty (vials) <input type="checkbox"/> Gonal-f 1050 IU multidose _____ qty (vials) <input type="checkbox"/> Gonal-f RFF 75 IU _____ qty (vials) Sig: _____ (= _____ days) _____ refills	<input type="checkbox"/> Endometrin vaginal tablet 100 mg _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> Prometrium 200 mg capsules _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> Medrol _____ mg tablets _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> Repronex 75 IU <input type="checkbox"/> Menopur 75 IU <input type="checkbox"/> IM SC _____ qty (vials) Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> 3cc 22G 1 ½" syringe/needles # _____ g _____ " needles	<input type="checkbox"/> Doxycycline 100 mg capsules _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> Clomid 50 mg _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> Bravelle 75 IU <input type="checkbox"/> IM <input type="checkbox"/> SC _____ qty (vials) Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> 3cc 22G 1 ½" syringe/needles # _____ g _____ " needles	<input type="checkbox"/> Estrace <input type="checkbox"/> 1 mg <input type="checkbox"/> 2mg tablets _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> Luveris 75 IU <input type="checkbox"/> IM <input type="checkbox"/> SC _____ qty (vials) Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> 3cc 22G 1 ½" syringe/needles # _____ g _____ " needles	<input type="checkbox"/> Estrace patch _____ mg <input type="checkbox"/> Viville dot _____ mg _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> Desogen <input type="checkbox"/> Mircette _____ qty Sig: _____ (= _____ days) _____ refills
	<input type="checkbox"/> HCG 10,000 IU <input type="checkbox"/> Novarel 10,000 IU <input type="checkbox"/> Pregnyl 10,000 IU Sig: _____ (= _____ days) _____ qty _____ refills <input type="checkbox"/> 3cc 22G 1 ½" syringe/needles # _____ g _____ " needles	<input type="checkbox"/> Other: _____ qty Sig: _____ (= _____ days) _____ refills <input type="checkbox"/> 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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