ameripharma SPECIALTY CARE

Fertility Referral Form

Phone#: 877-778-0318 Fax#: 877-778-0399

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ Male ☐ Female SSN: _____ Wt (kg/lbs): _____ Ht (cm/in): _____

Address: _____ Phone: _____ Alternate: _____

Caregiver Name: _____ Relation to Patient: _____ Phone: _____

Insurance Plan: _____ Plan ID: _____ BIN #: _____ PCN #: _____ GRP #: _____

Please fax a copy of the front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber Name: _____ DEA: _____ NPI: _____

Address: _____

Phone: _____ Alternate: _____ Fax: _____ Email: _____

If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis (ICD-10 code + description): ☐ _____ ☐ _____ ☐ _____

Allergies: ☐ NKDA ☐ Other: _____

Prescription (Medication, Dose, Strength, Directions, Quantity, Refills)			Prescription (Medication, Dose, Strength, Directions, Quantity, Refills)		
☐ Ganirelix Acetate	250mcg/0.5ml syringe		☐ Low Dose HCG		
☐ Cetrotide	☐ 0.25mg kit ☐ 3mg kit		☐ Insulin Syringe	0.5cc	
☐ Leuprolide Acetate	2-week kit		☐ Progesterone in oil	50mg/ml vial	
☐ Lupron (DAW)	2-week kit		☐ Progesterone in Cottonseed oil	50mg/ml vial	
☐ Insulin Syringe	0.5cc		☐ Progesterone in Olive oil	50mg/ml vial	
☐ Microdose Leuprolide	50mcg/0.1ml 10ml vial		☐ 3cc 18g 1.5" Syringe, 22g 1.5" Needle		
☐ Insulin Syringe	0.5cc		☐ Progesterone	_____ mg caps	
☐ Bravelle	75 unit vial		☐ Progesterone suppositories	_____ mg	
☐ Menopur	75 unit vial		☐ Crinone 8%	15 appl (26.1GM)	
☐ Repronex	75 unit vial		☐ Endometrin	100mg	
☐ Q-Cap IM (3cc syringe only, 25g 1.5" needle)			☐ Vivelle Dot	_____ mg patches	
☐ Q-Cap SubQ (3cc syringe only, 27g 0.5" needle)			☐ Estraderm	_____ mg patches	
☐ Follistim	75 unit AQ vial		☐ Estrace	_____ mg tablets	
☐ Follistim	150 unit AQ vial		☐ Femtrace	_____ mg	
☐ Follistim	300 unit AQ Cartridge		☐ Clomiphene Citrate	50mg tablets	
☐ Follistim	600 unit AQ Cartridge		☐ Methylprednisolone	_____ mg	
☐ Follistim	900 unit AQ Cartridge		☐ Doxycycline	100mg tablets	
☐ Follistim Pen			☐ Baby Aspirin	81mg tablets	
☐ Gonal-f RFF	75 unit vial		☐ Birth Control		
☐ Gonal-f RFF Redi-ject	300 unit pen		☐ Prenatal Vitamin		
☐ Gonal-f RFF Redi-ject	450 unit pen		☐ Folic Acid	1mg tablets	
☐ Gonal-f RFF Redi-ject	900 unit pen		☐ IM (3cc22g1.5" syringe, 25g 1.5" needle)		
☐ Gonal-f RFF	450 unit MDV		☐ SubQ (3cc22g1.5" syringe, 27g 0.5"needle)		
☐ HCG	10,000 unit vial		☐ Sharps container		
☐ Novarel	10,000 unit vial		☐ Patient Edu.		
☐ Ovidrel	250mcg syringe		☐		
☐ Pregnyl	10,000 unit vial		☐		

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above.
I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

Reset Form