Across Specialty Pharmacy

FERTILITY REFERRAL FORM

PH (770) 746 0130 | **FAX** (770) 746 0131
NCPDP 1175288 | **NPI** 1275142614

PATIENT INFORMATION

Last Name	First Name	DOB	Gender ☐M ☐F	Last 4 SSN	Primary Language
Address		City	State	ZIP	
Email	Home Phone	Work Phone	Cell Phone		
Primary Contact Method (check one) ☐Cell Phone ☐Home Phone ☐Work Phone ☐Text ☐Email ☐Primary Caregiver ☐DO NOT CONTACT					
Primary Caregiver/Alt Contact Name (If applicable)	Alt Contact Email	Alt Contact Phone			

PRESCRIBER INFORMATION

Name of Contact Sending Referral	Title	Preferred Contact Method (check one) ☐Email ☐Phone ☐Fax	
Referral Contact Email	Office Phone	Office Fax	
Practice / Facility Name	Prescriber Name / Specialty		
Address	City	State	ZIP
Prescriber State License #	DEA #	NPI #	Medicaid UPIN #

CLINICAL INFORMATION

Patient New to Therapy ☐Naïve/New Start ☐Therapy Restart ☐Existing Treatment	Date of Last Treatment	Therapy Start Date
Other/Concomitant Medications (please list)	Patient Height (cm/in):	Weight (kg/lbs): Date Obtained:
Allergies ☐NKDA ☐Drug Allergies (please list)		
Ship to Address ☐Home ☐Prescriber's Office ☐Other (please list)		
Check all that Apply ☐CRYO/AH ☐CRYO CYCLE ☐IVF ☐ISCI/AH ☐RECIPIENT (Egg Donation) ☐EGG DONOR ☐IUI (Partner) ☐IUI (Donor)		
ICD-10 Code ☐Code: Description:		

PRESCRIPTION INFORMATION

☐Cetrotide® 0.25mg ☐Ganirelix Acetate® 250mcg/0.5ml	____ Quantity ____ Refills	☐Progesterone Capsules ☐100mg ☐200mg	____ Quantity ____ Refills
☐Leuprolide Acetate 2 Week Kit ☐1/2cc 30G ½" insulin syringe #_____Refills_____ ☐Lupron Depot® 3.75mg	____ Quantity ____ Refills	☐Progesterone in Oil 50mg/ml 10ml vial ☐3cc syringe 18G 1 ½" needle #_____Refills_____ ☐22G 1 ½" needle #_____Refills_____	____ Quantity ____ Refills
☐Gonal-f® RFF Redi-ject™ 300IU ☐Gonal-f® RFF Redi-ject™ 450IU ☐Gonal-f® RFF Redi-ject™ 900IU	____ Quantity ____ Refills	☐Estradiol Tablets ☐0.5mg ☐1mg ☐2mg ☐Estradiol Patch ☐0.025mg ☐0.05mg ☐0.1mg ☐Vivelle Dot® Patch ☐0.025mg ☐0.05mg ☐0.1mg	____ Quantity ____ Refills
☐Gonal-f® Multi-Dose 450IU ☐Gonal-f® Multi-Dose 1050IU	____ Quantity ____ Refills	☐Crinone® 8% Gel Applicators ☐Endometrin® Vaginal Inserts 100mg ☐Medroxyprogesterone Tablets ☐2.5mg ☐5mg ☐10mg	____ Quantity ____ Refills
☐Follistim AQ® 300IU Cartridge ☐Follistim AQ® 600IU Cartridge ☐ Follistim AQ® 900IU Cartridge ☐Follistim Pen	____ Quantity ____ Refills	☐Clomiphene Citrate Tablets 50mg	____ Quantity ____ Refills
☐Menopur® 75IU Vial ☐3cc syringe #_____ Refills___ ☐27G ½" needle #_____ Refills___	____ Quantity ____ Refills	☐Doxycycline Capsules/Tablets 100mg ☐Methylprednisolone Tablets ☐4mg ☐8mg ☐16mg ☐Azithromycin Tablets 250mg	____ Quantity ____ Refills
☐Ovidrel® 250mcg ☐Novarel® 10,000IU Vial ☐Pregnyl® 10,000IU Vial ☐3cc syringe 25G 5/8" needle #_____Refills_____ ☐10ml syring #_____Refills_____ ☐3ml syringe #_____Refills_____ ☐22G 1 ½" needle #_____Refills_____	____ Quantity ____ Refills	☐Other	____ Quantity ____ Refills
		☐Other	____ Quantity ____ Refills
		☐Other	____ Quantity ____ Refills
		☐Other	____ Quantity ____ Refills

Additional Supplies Needed: ☐Sharps container Alcohol wipes, Qty _____

By signing this form, you authorize Across Specialty Pharmacy and its representatives to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient as well as help the patient apply for co-pay assistance programs, including all foundations and manufacturer assistance programs if necessary.

Prescriber Signature Date Supervising Physician Signature (where required by state law) Date

DAW (Dispense as Written) Date Brand Necessary (must handwrite)

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