FERTILITY REFERRAL FORM

Phone (888) 370.1724 Fax (877) 645.7514
10004 S. 152nd St, Suite A, Omaha NE 68138

AMBER SPECIALTY PHARMACY

Patient Information

PLEASE FAX INSURANCE CARD (FRONT AND BACK)

Last Name	First Name	DOB
Address		
City	State	ZIP
Phone	SSN	
Allergies	Latex Allergy ☐ Yes ☐ No	
Sex ☐ Male ☐ Female	Weight (kg)	Height (ft,in)
Insurance Plan	Plan ID #	

Prescriber Information

Practice/Facility Name		
Address		
City	State	ZIP
Prescriber Name		
Prescriber NPI		
Nurse/Key Contact	Phone/Pager	
Fax	Email	

Clinical Information

PLEASE FAX CLINICAL AND LAB INFORMATION

☐ CYRO/AH ☐ CRYO CYCLE ☐ IVF ☐ ISCI/AH ☐ RECIPIENT (Egg Donation) ☐ EGG DONOR ☐ IUI (Partner) ☐ IUI (Donor) ☐

Prescription Information

☐ **Cetrotide®** 0.25mg Sig:_____	____ Quantity ____ Refills
☐ **Ganirelix Acetate®** 250mcg/0.5ml ReUnite Sig:_____	____ Quantity ____ Refills
☐ **Leuprolide Acetate** 2 Week Kit Sig:_____ ☐ 1/2cc 30G ½" insulin syringe	____ Quantity ____ Refills _____# _____ Refills
☐ **Lupron Depot®** 3.75mg Sig:_____	____ Quantity ____ Refills
☐ **Gonal-f® RFF** Redi-ject™ 300IU ☐ **Gonal-f® RFF** Redi-ject™ 450IU ☐ **Gonal-f® RFF** Redi-ject™ 900IU Sig:_____	____ Each _____Refills ____ Each _____Refills ____ Each _____Refills
☐ **Gonal-f® Multi-Dose** 450IU ☐ **Gonal-f® Multi-Dose** 1050IU Sig:_____	____ Quantity ____ Quantity ____ Refills
☐ **Follistim AQ®** 300IU Cartridge ☐ **Follistim AQ®** 600IU Cartridge ☐ **Follistim AQ®** 900IU Cartridge ReUnite Sig:_____ ☐ Follistim Pen	____ Each _____Refills ____ Each _____Refills ____ Each _____Refills
☐ **Menopur®** 75IU Vial Sig:_____ ☐ 27G ½" needle ☐ 3cc syringe/22G 1 ½" needle	____ Quantity ____ Refills _____# _____ Refills _____# _____ Refills
☐ **Ovidrel®** 250mcg Sig:_____ ☐ **Novarel®** 10,000IU Vial Sig:_____ ☐ **Pregnyl®** 10,000IU Vial ReUnite Sig:_____ ☐ 25G 1 ½" needle ☐ 3cc syringe/22G 1 ½" needle	____ Quantity ____ Refills ____ Quantity ____ Refills

☐ **Progesterone Capsules** ☐ 100mg ☐ 200mg Sig:_____	____ Quantity ____ Refills
☐ **Progesterone in Oil** 50mg/ml 10ml vial Sig:_____ ☐ 18G 1 ½" needle ☐ 3cc syringe/22G 1 ½ needle	____ Quantity ____ Refills _____# _____ Refills _____# _____ Refills
☐ **Estradiol Tablets** ☐ 0.5mg ☐ 1mg ☐ 2mg Sig:_____	____ Quantity ____ Refills
☐ **Estradiol Patch** ☐ 0.025mg ☐ .05mg ☐ 0.1mg Sig:_____	____ Quantity ____ Refills
☐ **Vivelle Dot® Patch** ☐ 0.025mg ☐ 0.05mg ☐ 0.1mg Sig:_____	____ Quantity ____ Refills
☐ **Crinone® 8% Gel** Applicators Sig:_____	____ Quantity ____ Refills
☐ **Endometrin® Vaginal Inserts** 100mg Sig:_____	____ Quantity ____ Refills
☐ **Medroxyprogesterone Tablets** ☐ 2.5mg ☐ 5mg ☐ 10mg Sig:_____	____ Quantity ____ Refills
☐ **Clomiphene Citrate Tablets** 50mg Sig:_____	____ Quantity ____ Refills
☐ **Doxycycline Capsules/Tablets** 100mg Sig:_____	____ Quantity ____ Refills
☐ **Methylprednisolone Tablets** ☐ 4mg ☐ 8mg ☐ 16mg Sig:_____	____ Quantity ____ Refills
☐ **Azithromycin Tablets** 250mg Sig:_____	____ Quantity ____ Refills
☐ **Other** Sig:_____	____ Quantity ____ Refills
☐ **Other** Sig:_____	____ Quantity ____ Refills

Additional Supplies Needed: ☐ Sharps container ☐ Alcohol wipes (Qty _____)

DATE NEEDED _____ **Please attach copy of dosing calendar if available*

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary," or your state-specific required language to prohibit substitution: _____

PRODUCT SUBSTITUTION PERMITTED/Brand exchange permitted (date) _____

DISPENSE AS WRITTEN/Do Not Substitute (date) _____

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