FERTILITY DRUGS Referral Form

aureus
61 Doctors' Park
Cape Girardeau, MO 63703
Phone: 866-936-1999
Fax: 888-936-7234

Prescriber's Name: _____ MD / DO / NP / PA
Address: _____
City _____ State _____ Zip _____
Office Contact: _____ Phone# _____ Fax# _____
Office Contact: _____ Phone# _____ Fax# _____
NPI: _____ DEA: _____ License: _____

PATIENT INFORMATION Send updates to ❑ Fax ❑ E-mail to _____ ❑ Text to Phone# _____
Patient's Name: _____ SS# _____ DOB: _____
Address: _____ City _____ State _____ Zip _____
Home Phone: _____ Work or Cell: _____ Emergency Contact: _____
Allergies: _____ Sex: M____ F____ Wt: _____ Ht: _____ Diabetic: Y N
Patient previously on treatment: Y N Date: _____
Primary Insurance: _____ Policy# _____
Insured: _____ Group _____
Phone: _____ BIN# _____ PCN# _____

*** Please include current patient medication list with referral ***

MEDICAL ASSESSMENT

- Has Patient been treated previously for this condition? ❑ Yes ❑ No Medications: _____
- Is patient currently on therapy? ❑ Yes ❑ No Medications: _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑ Yes ❑ No If yes, what is the washout period?
- Other medications patient is currently taking including OTC mediations with dosage and direction (or fax medication profile:)
- **Patient has been given several options for teaching and patient is requesting AUREUS ❑ Yes**

LEUPROLIDE ACETATE®
1mg/0.2ml 2 Week Kit
Sig: _____ ____Qty ____Refills

LUPRON DEPOT®
____ mg
Sig: _____ ____Qty ____Refills

GANIRELIX ACETATE®
for injection 250mcg
Sig: _____ ____Qty ____Refills

CETROTIDE® ❑ 0.25mg ❑ 3mg
Sig: _____ ____Qty ____Refills

❑ FOLLISTIM® AQ Cartridge
❑ FOLLISTIM PEN®
Qty ❑ 300 IU ❑ 600 IU ❑ 900 IU
❑ FOLLISTIM 75 IU Vial
❑ FOLLISTIM 150 IU Vial
Sig: _____ ____Qty ____Refills

❑ GONAL-f® RFF PEN
❑ 300 IU ❑ 450 IU ❑ 900 IU
Sig: _____ ____Qty ____Refills

❑ GONAL-f® RFF Vials
❑ 450 IU ❑ 1050 IU ❑ 75 IU
Sig: _____ ____Qty ____Refills

❑ REPRONEX® ❑ IM ❑ SC
75 International Units
Sig: _____ ____Qty (Vials) ____Refills

❑ MENOPUR® ❑ IM ❑ SC
75 International Units
Sig: _____ ____Qty (Vials) ____Refills

❑ LUVERIS® ❑ IM ❑ SC
75 International Units
Sig: _____ ____Qty (Vials) ____Refills

❑ NOVAREL® 10,000 IU
❑ PREGNYL® 10,000 IU
Sig: _____ ____Qty ____Refills

❑ CLOMIPHENE CITRATE 50mg
Sig: _____ ____Qty ____Refills

❑ OVIDREL®
250mcg Prefilled Syringes
Sig: _____ ____Qty ____Refills

❑ MEDROL®
____ mg tablets
Sig: _____ ____Qty ____Refills

❑ DOXYCYCLINE®
100mg caps
Sig: _____ ____Qty ____Refills

❑ PROGESTERONE® in oil
50mg/ml 10ml vial
❑ PROGESTERONE® Ethyl Oleate
50mg/ml 10ml vial
Sig: _____ ____Qty ____Refills
❑ PROGESTERONE Suppositories
____ mg
Sig: _____ ____Qty ____Refills

❑ PROMETRIUM®
200mg capsules
Sig: _____ ____Qty ____Refills

❑ DESOGEN® ❑ MIRCETTE®
Sig: _____ ____Qty ____Refills

❑ CRINONE®
8% Gel - 15 per box
Sig: _____ ____Qty ____Refills

❑ ENDOMETRIN® Vaginal Tablet 100mg
Sig: _____ ____Qty ____Refills

❑ ESTRADIOL® ❑ 1mg ❑ 2mg tablets
Sig: _____ ____Qty ____Refills

❑ ESTRADIOL PATCH
____ mg
Sig: _____ ____Qty ____Refills

By signing this form and utilizing our services, you are authorizing Aureus and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature: _____ Date: _____
May Substitute _____ Dispense as Written