# FERTILITY REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

**Patient Information**

Patient Name: ______________________ DOB: ______________ Sex: ☐ M ☐ F

Phone: ______________ Cell Phone: ______________ Email Address: ______________

Address: ______________________ City: ______________ State: ______ Zip: ________

ICD-10 Diagnosis Code: ______________ Diagnosis: ______________________

Allergies (please note reaction): ______________________ ☐ Latex

Current Medications: (list here or attach a medication list): ______________________

______________________________________________

Comorbidities: (list here or attach a list): ______________________

**Prescription Information**

## INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ Makena (hydroxyprogesterone caproate) | ☐ 250mg/mL Multi-dose Vial (5 doses) | ☐ Administer 250mg intramuscularly once weekly (every 7 days) To be administered by a healthcare provider. | 35-day supply | |
| | ☐ 250mg/mL Single-Dose Vial | | 28-day supply | |
| Other Medication Name: | | | | |

## Treatment History: ☐ New to Therapy ☐ Continuation of Therapy

**Does patient have:**

**Current week of gestation** (if applicable): __________

Current or history of thrombosis or thromboembolic disorders? ☐ Yes ☐ No

Known, suspected or history of breast cancer or other hormone-sensitive cancer? ☐ Yes ☐ No

Undiagnosed abnormal vaginal bleeding (unrelated to pregnancy)? ☐ Yes ☐ No

Cholestatic jaundice of pregnancy? ☐ Yes ☐ No

Liver tumors or active liver disease? ☐ Yes ☐ No

Uncontrolled hypertension? ☐ Yes ☐ No

**Prescriber Information**

Prescriber Name: ______________________________

State License #: ______________ DEA #: ______________ NPI: ______________

Additional Contact Person Name: ______________________________

Group or Hospital: ______________________ Phone: ______________

Fax: ______________ Email Address: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ____________

Prescriber Signature:

______________________ Product Substitution Permitted ________ Date ______________________ Dispensed as Written ________ Date

**Delivery Information**

Ship to: ☐ Patient ☐ Prescriber/Clinic

☐ Pick up at an Albertsons Companies Pharmacy

Address: ______________________________

Phone: ______________________________

Date Medication Needed: ______________________________

Ph. 800-834-8778
Fax 877-466-8040

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100