FERTILITY REFERRAL FORM

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

Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

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 | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____

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