ivira specialty pharmacy

Women's Health Referral Form

Please fax completed referral form to ivira:
(302) 499-8729

Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	GENDER: ☐ F ☐ M
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

- ☐ N80.0 - Endometriosis of uterus
- ☐ N80.1 - Endometriosis of overary
- ☐ N80.2 - Endometriosis of fallopian tube
- ☐ N80.3 - Endometriosis of pelvic peritoneum
- ☐ N80.4 - Endometriosis of rectovaginal septum & vagina
- ☐ N80.5 - Endometriosis of intestines
- ☐ N80.6 - Endometriosis in scar of skin
- ☐ N80.8 - Endometriosis of other unspecified sites
- ☐ N80.9 - Endometriosis site, unspecified
- ☐ D25.9 - Uterine leiomyoma, unspecified
- ☐ OTHER: _____ - _____

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

PATIENT CONSENT & AUTHORIZATION:

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

▶▶▶▶▶▶▶▶ PATIENT SIGNATURE:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. MOST RECENT LABS ☐ 3. PATIENT DEMOGRAPHICS ☐ 4. H&P

MEDICATION SELECTION:

Hydroxyprogesterone Caporate Injection	☐ 250mg/ml 1ml SDV	☐ Inject 1 mL each week (every 7 days)	QTY: 1 Month REFILLS:_____
Lupeneta Pack™	☐ 11.25 mg & 5 mg Pack ☐ 3.75 mg & 5 mg Pack	☐ Use as directed on pack	QTY: 1 Month REFILLS:_____
Lupron Depot®	☐ 3 Month, Inject 11.25 mg ☐ 3.75 mg	☐ Inject IM every 3 months ☐ Inject IM every 1 month	QTY: 1 Month REFILLS:_____
Makena® (Hydroxyprogesterone Caporate Injection)	☐ 275mg/1.1ml Autoinjector	☐ Inject 1.1 mL each week (every 7 days)	QTY: 1 Month REFILLS:_____
Orilissa®	☐ 150 mg tablet ☐ 200 mg tablet	☐ Take 1 tablet by mouth once daily ☐ Take 1 tablet by mouth twice daily	QTY:_____ REFILLS:_____
Zoladex®	☐ 3.6 mg, 1-month	☐ Inject 3.6 mg SC every 4 weeks	QTY: 1 Month REFILLS:_____

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

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PHYSICIAN SIGNATURE: DATE: