



Pharmacy Fertility Agent Request Form

Fax this form and supporting chart notes to (503) 346-8351

Patient Information

Last Name:	First Name:
ID#:	Date of Birth:

Prescriber Information

Last Name:	First Name:	
NPI #:	Phone #:	Fax #:
Address:		

Medication Information

Name:	Strength:	Directions:
Name:	Strength:	Directions:
Name:	Strength:	Directions:

Female or assigned female at birth (Select all that apply):

- 35 years of age or younger with failure to conceive after regular unprotected sexual intercourse for one year or more
- 35 years of age or older with failure to conceive after regular unprotected sexual intercourse for six months or more
- Requiring medical assistance to conceive (e.g. oligoovulation due to PCOS) including same-sex couples and single persons using partner or donor gametes
- Prior diagnosis of infertility
- Recurrent pregnancy loss defined as two or more pregnancy losses (miscarriages) prior to twenty weeks gestation
- Prior cycle of in vitro fertilization or intracytoplasmic sperm injection with failure
- Premature ovarian insufficiency or decreased ovarian reserve due to gonadotoxic therapy
- Fertility preservation (oocyte/embryo/ovarian tissue banking) prior to gonadotoxic therapy
- History of bilateral oophorectomy
- Carrier of a genetic disease (or affected by a genetic disease) and/or has a partner who is a carrier of a genetic disease (or affected by a genetic disease) and at risk of having a child with a genetic disease

Male partner or assigned male at birth (Select all that apply):

- Infertility due to gonadotoxic therapy (e.g., orchiectomy or chemotherapy or lupus therapy)
- Fertility preservation (sperm/testicular tissue banking) prior to gonadotoxic therapy
- Non-obstructive azoospermia or severe oligospermia
- Paraplegia and sperm retrieval required to achieve pregnancy
- HIV positive AND adherent with antiretroviral therapy AND washed sperm needed for insemination
- Carrier of a genetic disease (or affected by a genetic disease) and/or has a partner who is a carrier of a genetic disease (or affected by a genetic disease) and at risk of having a child with a genetic disease

I attest that the patient is eligible for infertility treatment and that the information provided is accurate and true.

Prescriber Signature: _____

Date: _____

Confidentiality Notice: The documents accompanying this transmission contain confidential information that is legally privileged. If you are not the intended recipient, please immediately notify the sender and dispose of these documents.

For questions, contact OHSU PBM Services at 1-833-631-7991