

INTRAUTERINE DEVICE REFERRAL FORM

Prescriber, please sign and fax completed form to 713.704.3841 For questions, please call 281.698.6100

SHIP TO:	☐ Prescriber Office ☐ Other:

Patient Information **	*Please include copy of prescription and me	edical insurand	ce card	d, front and back**	
Patient Name:		Date of Birth:			
Street Address:		Phone:			
City, State, Zip:		Allergies:			
Prescriber Information					
Prescriber Name:		NPI:			
Specialty:		Phone:			
Office Street Address:		Fax:			
City, State, Zip:		Office Contact:			
Patient Medical Information	**Please include copies of any pertir	nent clinical no	otes ar	nd lab work **	
Diagnosis (ICD-10): Signature Image: Independent of the contract of the c		ycle		Date of last menses:	
				nsertion date (if scheduled):	
			·		
Prescription Information	Instructions	(Quanti	ty	
☐ Kyleena (levonorgestrel-releasingintrauterine system) 19.5 mg	☐ To be inserted one time by prescriber (intrauterine		#1	No Refills	
☐ Mirena (levonorgestrel-releasingintrauterine system) 52 mg	☐ To be inserted one time by prescriber (intraute		#1	No Refills	
Skyla (levonorgestrel-releasingintrauterine system) 13.5 mg	☐ To be inserted one time by prescriber (intrauterin		#1	No Refills	
Prescriber Signature (No Stamps Per					
By signing below, I authorize Memorial Hermann Specialty Pharmacy to serve as my designated agent, if needed, to initiate and execute any applicable authorization processes with medical and prescription insurance companies. To prohibit generic substitution write "brand necessary" or "brand medically necessary" on the face of the prescription in your own handwriting.					
Prescriber's Signature : Date:					

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