MEMORIAL HERMANN
Specialty Pharmacy

# 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 medical insurance card, 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 pertinent clinical notes and lab work **

Diagnosis (ICD-10):

- ☐ Z30.430 – Encounter for insertion of intrauterine contraceptive device
- ☐ N92.0 – Excessive and frequent menstruation with regular cycle
- ☐ N92.4 – Excessive bleeding in the premenopausal period
- ☐ Other ____________________

Date of last menses: ____________________

Insertion date (if scheduled): ____________________

## Prescription Information

| Prescription Information | Instructions | Quantity | |
|---|---|---|---|
| ☐ **Kyleena** (levonorgestrel-releasing intrauterine system) 19.5 mg | ☐ To be inserted one time by prescriber (intrauterine) | #1 | No Refills |
| ☐ **Mirena** (levonorgestrel-releasing intrauterine system) 52 mg | ☐ To be inserted one time by prescriber (intrauterine) | #1 | No Refills |
| ☐ **Skyla** (levonorgestrel-releasing intrauterine system) 13.5 mg | ☐ To be inserted one time by prescriber (intrauterine) | #1 | No Refills |

## Prescriber Signature (No Stamps Permitted)

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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