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:**
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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:** _____

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