Contraceptive Device Prescription Form

Please complete the request form and fax it to Desert Hospital Outpatient Pharmacy; Fax Number: (877) 354-6679

Member Information	Provider Information
Member Name:	**Provider Name:**
IEHP ID:	**NPI:**
DOB:	**Office Phone:**
Address:	**Address:**

PLEASE NOTE: Physician office, please notify Desert Hospital Outpatient Pharmacy at (760) 323-1001 of any cancellations and/or rescheduling of the device insertion.

Please check appropriate diagnosis box:

☐ Diagnosis: Pregnancy prevention; contraception

☐ Other:____

____

Additional Information:

☐ Member understands the IEHP coverage policy for the requested device is limited to one device for the following duration:

Drug	Dosing	Duration	Quantity Limits
Liletta (levonorgestrel)	19.6 mcg/day	Provides efficacy up to 3 years	1 per 4 years
Mirena (levonorgestrel)	20 mcg/day	Provides efficacy up to 5 years	1 per 5 years
ParaGard (copper)	--	Provides efficacy up to 10 years	1 per 10 years
Skyla (levonorgestrel)	6 mcg/day	Provides efficacy up to 3 years	1 per 3 years
Kyleena (levonorgestrel)	17.5mcg/day	Provides efficacy up to 5 years	1 per 5 years
Nexplanon (etonogestrel)	68mg	Provides efficacy up to 3 years	1 per 3 years

☐ Insertion date of device: ____/_____/_____

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Please circle the requested device and respective duration below:

Liletta / Mirena / ParaGard / Skyla / Kyleena / Nexplanon

Sig: Insert as directed

Quantity: One (1)

Signature: **Date:**