

FC2 Female Condom® (Internal Condom) Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealisp.com



Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

FC225-01

| PATIENT INFORMATION | | | | |
|--------------------------------|---|--|---|--|
| First Name | Last Name | Middle Initial | Suffix <input type="checkbox"/> None <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Jr. <input type="checkbox"/> Sr. | |
| Date of Birth ___ / ___ / ____ | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex | Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Nonbinary <input type="checkbox"/> Other _____ | | |
| Address | City | State | Zip | |
| email | Home Phone | Cell Phone | | |

| PRESCRIBER INFORMATION | | | | |
|-------------------------|-----------------------|---|------------|--|
| Prescriber Full Name | Prescriber Credential | | | |
| Practice Address | City | State | Zip | |
| Office email | Office Phone | Office Fax | Cell Phone | |
| Practice Contact Person | Prescriber NPI | Preferred Contact Method <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Fax | | |

| CLINICAL INFORMATION – please include any relevant office visit/lab notes to support this prescription | |
|--|--|
| Patient is <input type="checkbox"/> Naïve / New Start <input type="checkbox"/> Therapy Restart <input type="checkbox"/> Existing Treatment | Therapy Start Date ___ / ___ / ____ |
| Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies (please list) | |
| Therapies Tried and Failed (please check name and include dates) | Reason for therapeutic failure/therapy not tried |
| <input type="checkbox"/> Male “external” condom <input type="checkbox"/> Oral birth control tablets <input type="checkbox"/> IUD/Implant <input type="checkbox"/> Diaphragm <input type="checkbox"/> Spermicide <input type="checkbox"/> STI Prophylactic Medication (ex. Descovy) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Not covered by insurance <input type="checkbox"/> Adherence concerns <input type="checkbox"/> Not compatible with preferred lubricant <input type="checkbox"/> Size not compatible <input type="checkbox"/> Patient refusal <input type="checkbox"/> Other: _____ |
| Current Medications (please list name and dose) | |
| ICD-10 Code | <input type="checkbox"/> Z30.018 – Encounter for initial prescription, other contraceptive <input type="checkbox"/> Z30.019 – Encounter for initial prescription, unspecified <input type="checkbox"/> Z30.09 – Encounter for general counseling, contraceptive <input type="checkbox"/> Z30.8 – Encounter for other contraceptive management |
| | <input type="checkbox"/> Z30.9 – Encounter for contraceptive management, unspecified <input type="checkbox"/> Z30.40 – Encounter for surveillance of contraceptive, unspecified <input type="checkbox"/> Z30.49 – Encounter for surveillance of other contraceptives <input type="checkbox"/> Other: _____ |

| PRESCRIPTION – please check all boxes across row – *Please Note: Zeal does not split pre-packaged boxes | | | |
|---|---|---|--|
| Medication | Directions | Quantity* | Refills |
| <input type="checkbox"/> FC2 Female Condom® (Internal Condom) | Insert into vagina prior to sexual activity as directed on the box. | <input type="checkbox"/> One 12-count box (12) <input type="checkbox"/> Two 12-count boxes (24) <input type="checkbox"/> Three 12-count boxes (36) <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 0 <input type="checkbox"/> 11 <input type="checkbox"/> Other: _____ |

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ MD DO PA CRNP Date: ___ / ___ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite “Brand Necessary” or “Brand Medically Necessary” on the prescription.

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.

| SHIPPING INFORMATION | |
|---|---|
| Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Physician/Clinic | Date Shipment Needed By: ___ / ___ / ____ |