PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.
Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital **(may not be faxed by patient)**.

Clinic Name: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____

Prescription/Pharmacy Intake Form
For office use only

Today's Date: _____ **Anticipated Start Date (REQUIRED):** _____
Name: _____ **DOB:** _____ **Allergies:** _____
Address: _____
Home: _____ **Work:** _____ **Cell:** _____
ICD-10: _____ **Cycle#:** _____ **Cycle Type**: ☐ IUI ☐ IVF ☐ FET **Insurance** ☐ : Copy of card (front and back)

☐ Desogen ☐ Other: _____ ____ Qty (Packs)
Sig.: _____ (= ___ days) ____ Refills

☐ leuprolide acetate 1mg/0.2ml – 2 week kit – 14mg/2.8ml MDV ____ Qty (Kits)
Sig.: _____ (= ___ days) ____ Refills

☐ Microdose leuprolide acetate 5ml MDV (compounded*)
☐ 20mcg/0.1ml
☐ 40mcg/0.1ml
☐ 50mcg/0.1ml
☐ #____ 0.5ml Insulin Syringes ____ Qty (Vials)
Sig.: _____ (= ___ days) ____ Refills

☐ Leuprolide acetate Trigger (PFS) (compounded*)
☐ 1 MG/0.2mL (=20 units) ____ Qty (PFS)
☐ 2 MG/0.4mL (=40 units) ____ Qty (PFS)
☐ 4 MG/0.8mL (=80 units) ____ Qty (PFS)
Sig.: _____ (= ___ days) ____ Refills

☐ Ganirelix 250 mcg/0.5mL Injection ____ Qty
☐ Fyremadel 250 mcg/0.5mL Injection ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Cetrotide 0.25mg ____ Qty (Kits)
Sig.: _____ (= ___ days) ____ Refills

☐ Follistim AQ Cartridge ☐ Follistim Pen
☐ 300 International Units ____ Qty
☐ 600 International Units ____ Qty
☐ 900 International Units ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Gonal-f RFF Redi-ject
☐ 300 International Units ____ Qty
☐ 450 International Units ____ Qty
☐ 900 International Units ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Gonal-f Multi-Dose 450 International Units ____ Qty (Vials)
☐ Gonal-f Multi-Dose 1050 International Units ____ Qty (Vials)
☐ Gonal-f RFF 75 International Units ____ Qty (Vials)
Sig.: _____ (= ___ days) ____ Refills

☐ Menopur 75 International Units ____ Qty (Vials)
☐ #____ 3ml 22g 1 ½" syringes/needles ☐ #____ _____g _____" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Ovidrel 250mcg Prefilled Syringes ____ Qty (PFS)
Sig.: _____ (= ___ days) ____ Refills

☐ Micro HCG ALFA 2.5mcg/0.1ml per 2ml MDV (compounded*) ____ Qty (Vials)
☐ #____ 0.5ml Insulin Syringes
Sig.: _____ (= ___ days) ____ Refills

☐ Low Dose HCG 5ml MDV (compounded*) ____ Qty (Vials)
☐ 10 USP Units/0.1ml
☐ #____ 0.5ml Insulin Syringes
Sig.: _____ (= ___ days) ____ Refills

☐ HCG 10,000 USP Units ____ Qty (Vials)
☐ Novarel 5,000 USP Units ____ Qty (Vials)
☐ Pregnyl 10,000 USP Units ____ Qty (Vials)
☐ #____ 3ml 22g 1 ½" syringes/needles ☐ #____ _____g _____" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Crinone 8% Gel – 15 applicators per box ____ Qty (Applicators)
Sig.: _____ (= ___ days) ____ Refills

☐ Endometrin Vaginal Insert 100mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Progesterone in Sesame Oil 50mg/ml 10ml Vial ____ Qty (Vials)
☐ #____ 3ml 18g 1 ½" needle ☐ #____ 22g 1 ½" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Progesterone Suppositories (compounded)
☐ 25mg ____ Qty (Supps)
☐ 50mg ____ Qty (Supps)
☐ 100mg ____ Qty (Supps)
☐ 200mg ____ Qty (Supps)
☐ 300mg ____ Qty (Supps)
☐ 400mg ____ Qty (Supps)
Sig.: _____ (= ___ days) ____ Refills

☐ Prometrium ☐100mg ☐200mg ____ Qty (Caps)
Sig.: _____ (= ___ days) ____ Refills

☐ Progesterone capsules (compounded)
☐ 50mg ____ Qty (Caps)
☐ 100mg** ____ Qty (Caps)
☐ 200mg** ____ Qty (Caps)
☐ 300mg ____ Qty (Caps)
☐ 400mg ____ Qty (Caps)
Sig.: _____ (= ___ days) ____ Refills
**For vaginal use or peanut allergy only

☐ Methylprednisolone _____mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Doxycycline 100mg ____ Qty (Caps)
Sig.: _____ (= ___ days) ____ Refills

☐ Clomiphene Citrate 50mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Estradiol
☐ 1mg ____ Qty (Tabs)
☐ 2mg ____ Qty (Tabs)
Sig.: _____ (= ___ days) ____ Refills

☐ Minivelle ____ Qty (Patches)
☐ Vivelle ____ Qty (Patches)
☐ Climara ____ Qty (Patches)
Sig.: _____ (= ___ days) ____ Refills

☐ Other: _____ ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ **FILL TOTAL PRESCRIPTION**

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

Prescriber's name: _____
State license #: _____ DEA #: _____ NPI #: _____ Medicaid UPIN #: _____
In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature.
I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

_____ Dispense as written
_____ Substitution permitted
_____ Date

***** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA *** The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.** The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.
Drug names are the property of their respective owners.

allianceRx
Walgreens Pharmacy

Specialty360 Fertility Team
Phone: 800-424-9002
Fax: 866-742-4986