

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).

Prescription/Pharmacy Intake Form

For office use only

Clinic Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

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 _____ Qty (Kits)
Sig.: _____ (= ___ days) _____ Refills

Microdose leuprolide acetate _____mcg/ _____ml 10ml vial
 # _____ 0.5ml Insulin Syringes _____ Qty (Vials)
Sig.: _____ (= ___ days) _____ Refills

Leuprolide acetate Trigger
 1 MG/0.2mL _____ Qty (Vials)
 2 MG/0.4mL _____ Qty (Vials)
 4 MG/0.8mL _____ Qty (Vials)
Sig.: _____ (= ___ days) _____ Refills

Ganirelix Acetate for Injection 250mcg _____ 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 1/2" syringes/needles # _____ g _____" needles
Sig.: _____ (= ___ days) _____ Refills

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

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

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

Low Dose HCG _____ Qty (Vials)
 10 International Units/0.1ml
 _____ International Units/ _____ml
 # _____ 0.5ml Insulin Syringes _____ Refills
Sig.: _____ (= ___ days) _____ Refills

HCG 10,000 International Units _____ Qty (Vials)
Novarel 5,000 International Units 10,000 International Units _____ Qty (Vials)
 Pregnyl 10,000 International Units _____ Qty (Vials)
 # _____ 3ml 22g 1 1/2" 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 1/2" needle # _____ 22g 1 1/2" needles
Sig.: _____ (= ___ days) _____ Refills

Progesterone Suppositories _____mg _____ Qty
Sig.: _____ (= ___ days) _____ Refills

Prometrium _____mg _____ Qty (Caps)
Sig.: _____ (= ___ days) _____ Refills

Progesterone capsules (compounded)
 50mg _____ Qty (Caps)
 300mg _____ Qty (Caps)
 400mg _____ Qty (Caps)
Sig.: _____ (= ___ days) _____ Refills

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

Estradiol Patch _____mg _____ Qty (Patches)
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

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.