

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 – 14mg/2.8ml MDV Qty (Kits) _____
Sig.: _____ (= ___ days) _____ Refills _____

Microdose leuprolide acetate 5ml MDV (compounded*)
 20mcg/0.1ml _____ Qty (Vials) _____
 40mcg/0.1ml _____ Qty (Vials) _____
 50mcg/0.1ml _____ Qty (Vials) _____

_____ 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 _____
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 _____

Micro HCG ALFA 2.5mcg/0.1ml per 2ml MDV (compounded*) _____ Qty (Vials) _____
 # _____ 0.5ml Insulin Syringes _____ Qty (Vials) _____

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

Low Dose HCG 5ml MDV (compounded*) _____ Qty (Vials) _____
 10 USP Units/0.1ml _____ Qty (Vials) _____
 # _____ 0.5ml Insulin Syringes _____ Qty (Vials) _____

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 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 (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 (Caps) _____
Sig.: _____ (= ___ days) _____ Refills _____

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

Clomiphene Citrate 50mg _____ Qty (Caps) _____
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

***AS PER USP 797 ALL STERILE COMPOUNDS WILL HAVE A MAXIMUM BEYOND USE DATE OF 10 DAYS**

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.

FOR OFFICE USE ONLY



City, State:

Phone:

Fax: