

1 PATIENT INFORMATION

Patient's Name _____

Date of Birth _____ Male Female Last 4 digits of SSN _____

Street Address _____ Apt# _____

City _____ State _____ Zip _____

Parent/Guardian (if applicable) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Evening Phone _____

E-mail address _____

Insurance Company Name _____

Insurance Company Phone No. _____

Insured's Name _____

Insured's Employer _____

Relationship to Patient _____

Identification No. _____ Policy/Group No. _____

Prescription Card No Yes If Yes, Carrier _____

Policy No. _____ Group No. _____

Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____

Prescriber's Name and Title _____

Office Contact _____

Clinic / Hospital Affiliation _____

Street Address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI No. _____ License No. _____

DEA No. _____

Physician Medicaid UPIN No. _____

MD Specialty _____

3 CLINICAL INFORMATION

Primary ICD-9 Code _____

Medication		Dose & Directions	Quantity	Refills
Gonadotropins				
Bravelle®	<input type="checkbox"/> 75 IU			
Follistim AQ® (vial)	<input type="checkbox"/> 75 IU <input type="checkbox"/> 150 IU			
Follistim AQ® (Cartridge)	<input type="checkbox"/> 150 IU <input type="checkbox"/> 300 IU <input type="checkbox"/> 600 IU <input type="checkbox"/> 900 IU			
Follistim AQ® (Pen Device)				
Gonal-F®	<input type="checkbox"/> 450 IU multi dose vial			
Gonal-F RFF® (vial)	<input type="checkbox"/> 75 IU			
Gonal-F RFF® (Pen)	<input type="checkbox"/> 300 IU <input type="checkbox"/> 450IU <input type="checkbox"/> 900 IU			
Luveris®	<input type="checkbox"/> 75 IU			
Menopur®	<input type="checkbox"/> 75 IU			
Repronex®	<input type="checkbox"/> 75 IU <input type="checkbox"/> 150 IU			
Human Chorionic Gonadotropin				
Chorionic	<input type="checkbox"/> 10,000 units			
Gonadotropin® (generic)				
Novarel®	<input type="checkbox"/> 10,000 units			
Ovidrel®	<input type="checkbox"/> 250 mcg Pre-filled syringe			
Pregnyl®	<input type="checkbox"/> 10,000 units			
GnRH Agonists				
Lupron®	<input type="checkbox"/> 5 mg/ml 14 day kit			
Leuprolide Acetate® (generic)				
GnRH Antagonists				
Cetrotide®	<input type="checkbox"/> 0.25 mg <input type="checkbox"/> 3 mg			
Ganirelix Acetate®	<input type="checkbox"/> 250 mcg Pre-filled syringe			

Supplies (if needed per dose)

- 20g 5/8" (mixing needle) 25g 5/8" (administration) needle
- 22g 1-1/2" (mixing or administration) needle 3ml (mixing) syringe

Deliver product to: Office Patient's Home Clinic

Clinic Location _____

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary.

Prescriber's Printed Name _____

Prescriber's Signature (sign below) _____ **Date** _____

Dispense as Written

Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)

To reach your team, call toll-free 1 888 608-9010.
Please fax completed form to the Infertility team
1 888 302-1028.