Fax: 800-218-3221

Phone: 800-850-9122

Infertility Enrollment Form

(see Page 2 for Donor, if needed)

PATIENT INFORMATION

Please complete the following or send patient demographic sheet

Patient Name ______________________________

Address ______________________________

City, State, ZIP ______________________________

Home Phone ______________ Alternate Phone ______________

DOB __________ Last Four of SS# __________ Gender __________

Language Preference: ☐ English ☐ Spanish ☐ Other __________

PRESCRIBER INFORMATION

Prescriber's Name ______________________________

DEA ______________ NPI ______________

Address ______________________________

City, State, ZIP ______________________________

Phone ______________ Fax ______________

Office Contact ______________________________

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Plan Name ______________________ Prior Authorization Reference Number ______________________

BIN __________ PCN __________ Group __________ Cardholder ID ______________________

MEDICAL INFORMATION *(Section must be completed to process prescription)* (Attach separate sheet if needed)

Diagnosis – Please include diagnosis name with ICD-10 code

ICD-10 Code ______________ Description ______________________________

Allergies ______________________ Concomitant Medications ______________________

PRESCRIPTION INFORMATION *(For recipient only. Use Page 2 for donor)*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cetrotide Kit	☐ 0.25mg			
☐ Crinone 8%		Use 1 appl PV ________ times a day		
☐ Endometrin Vaginal Inserts	☐ 100mg	Use 1 insert PV ________ times a day		
☐ Estrace	☐ 0.5mg ☐ 1mg ☐ 2mg	Titrate up to _____ tab(s) per day as directed ☐ PO ☐ PV		
☐ Follistim AQ Cartridge ☐ BD Needles #10 ☐ PEN	☐ 300 IU ☐ 600 IU ☐ 900 IU	Inject as directed. <Up to ________ units per day>		
☐ Ganirelix PFS	☐ 250 mcg/0.5 mL	Inject #______ PFS SQ QD		
☐ Gonal-f RFF	Pen: ☐ 300 IU ☐ 450 IU ☐ 900 IU SDV: ☐ 75 IU	Inject as directed. <Up to ________ units per day>		
☐ Gonal-f	MDV: ☐ 450 IU ☐ 1050 IU	Inject as directed. <Up to ________ units per day>		
☐ Human Chorionic Gonadotropin (hCG)	☐ 10,000 IU	Mix with _____ mL and inject _______ units/mL when directed (IM) (SQ)		
☐ Leuprolide Two Week Kit ☐ (10) Extra ½cc Insulin Syringes	☐ 1 mg/0.2 mL			
☐ Menopur	☐ 75 IU	Inject as directed. <Up to ________ units per day>		
☐ Novarel	☐ 5,000 IU	Mix with _____ mL and inject _______ units/mL when directed (IM) (SQ)		
☐ Ovidrel PFS	☐ 250 mcg/0.5 mL	Inject # ______ PFS when directed		
☐ Pregnyl	☐ 10,000 IU	Mix with _____ mL and inject _______ units/mL when directed (IM) (SQ)		
☐ Progesterone in Sesame Oil 50mg/mL		Inject __________ mL(s) __________ times a day		
☐ Progesterone	☐ 100mg ☐ 200mg	Use ________ cap(s) (PO / PV) __________ times a day		
☐ Vivelle Dot 0.1mg/24 hr (#8/Box) ☐ Minivelle 0.1mg/24 hr (#8/Box)		Use as directed up to # ________ patch(es) every ______ day(s)		
☐ Doxycycline	☐ 100mg	Take 1 capsule by mouth BID		
☐ Medrol	☐ 4mg ☐ 8mg ☐ 16mg	Take _______ tab(s) _______ times a day for ________ day(s)		
☐ Other				

Ship to: ☐ Infertility Center ☐ Patient's Home ☐ Other ______________________________

Date __________ Date Needed ______________ Faxed by ______________________

**Prescriber Authorization:* I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______________________ Date __________

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Fax: 800-218-3221

Phone: 800-850-9122

Infertility Enrollment Form – Donor

DONOR INFORMATION

Please complete the following or send patient demographic sheet

Donor Name ______________________

Address ______________________

City, State, ZIP ______________________

☐ Known ☐ Anonymous Phone ______________________

DOB __________ Donor ID______________________

Nurse______________________

PRESCRIBER INFORMATION

Prescriber's Name ______________________

DEA __________ NPI __________

Address ______________________

City, State, ZIP ______________________

Phone __________ Fax __________

Office Contact ______________________

INSURANCE INFORMATION *(Must fax a copy of patient's insurance card including both sides)*

Plan Name ______________________ Prior Authorization Reference Number ______________________

BIN __________ PCN __________ Group __________ Cardholder ID __________

MEDICAL INFORMATION *(Section must be completed to process prescription)* *(Attach separate sheet if needed)*

Diagnosis – Please include diagnosis name with ICD-10 code

ICD-10 Code __________ Description ______________________

Allergies ______________________ Concomitant Medications ______________________

PRESCRIPTION INFORMATION *(For donor only. Use Page 1 for recipient)*

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Cetrotide Kit	☐ 0.25mg			
☐ Crinone 8%		Use 1 appl PV ________ times a day		
☐ Endometrin Vaginal Inserts	☐ 100mg	Use 1 insert PV ________ times a day		
☐ Estrace	☐ 0.5mg ☐ 1mg ☐ 2mg	Titrate up to _____ tab(s) per day as directed ☐ PO ☐ PV		
☐ Follistim AQ Cartridge ☐ BD Needles #10 ☐ PEN	☐ 300 IU ☐ 600 IU ☐ 900 IU	Inject as directed. <Up to ________ units per day>		
☐ Ganirelix PFS	☐ 250 mcg/0.5 mL	Inject #______ PFS SQ QD		
☐ Gonal-f RFF	Pen: ☐ 300 IU ☐ 450 IU ☐ 900 IU SDV: ☐ 75 IU	Inject as directed. <Up to ________ units per day>		
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☐ Doxycycline	☐ 100mg	Take 1 capsule by mouth BID		
☐ Medrol	☐ 4mg ☐ 8mg ☐ 16mg	Take _______ tab(s) _______ times a day for ________ day(s)		
☐ Other				

Ship to: ☐ Office ☐ Donor's Home ☐ Other ______________________

Date __________ Date Needed __________ Faxed by __________

**Prescriber Authorization:* I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

☐ Product Substitution permitted ☐ Dispense as Written

Prescriber's Signature ______________________ Date __________

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