

<input type="checkbox"/> New to Therapy
<input type="checkbox"/> Current Therapy

Patient Information	Prescriber Information
Patient Name: _____ Date of Birth: _____ Gender: _____ SS# _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ E-mail: _____ Patient Weight: _____ kg/lbs Patient Height: _____ in/cm Please attach copy of front and back of patient's prescription ins. card(s) if applicable Insurance Company Name: _____ Insurance Company Phone: _____ Policy holder: _____ Policy holder Employer: _____ Relationship to Patient: _____ ID# _____ Group# _____ RxBIN: _____ RxPCN: _____	Practice/ Organization Name: _____ Physician Name: _____ Contact Person: _____ Contact's Phone: _____ Address: _____ City: _____ State: _____ Zip: _____ Office Phone#: _____ Office Fax#: _____ DEA# _____ NPI# _____ License#: _____ Medicaid UPIN#: _____ Physician Specialty: _____ Diagnosis(ICD-10): _____ Date Shipment Needed: _____ Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber <input type="checkbox"/> Other _____ Shipment Address: _____ Attn: _____ City: _____ State: _____ Zip: _____ <i>If shipped to the physician's office, physician accepts on behalf of patient for administration in office.</i>

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.

Patient Name: _____ **Patient Date of Birth:** _____

Prescriber Name: _____ **Phone:** _____ **Date:** _____

Prescriber Address: _____

Prescription Information

<input type="checkbox"/> Cetrotide® 0.25mg Syringe	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Ganirelix® 250mcg/0.5ml Syringe	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Leuprolide® 2-week kit	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Follistim AQ® (follitropin) <input type="checkbox"/> 300IU cartridge <input type="checkbox"/> 600IU cartridge <input type="checkbox"/> 900IU cartridge	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Follistim Pen device (Reusable and only needed for first shipment of medication)			
<input type="checkbox"/> Gonal-F® <input type="checkbox"/> 450IU MDV <input type="checkbox"/> 1050IU MDV	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Gonal-f RFF® Rediject pen <input checked="" type="checkbox"/> 300IU <input type="checkbox"/> 450IU <input type="checkbox"/> 900IU	Directions: _____	Quantity: _____	Refills: _____

If Brand required "Dispense as Written" must be handwritten

Prescriber Signature: X _____ **Date:** _____

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Patient Name: _____ **Patient Date of Birth:** _____

Prescriber Name: _____ **Phone:** _____ **Date:** _____

Prescriber Address: _____

<input type="checkbox"/> Menopur® 75IU vial (menotropins)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> HCG® 10,000 unit vial (human chorionic gonadotropin)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Novarel® 5,000 unit vial (human chorionic gonadotropin)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Pregnyl® 10,000 unit vial (human chorionic gonadotropin)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Ovidrel® 250mcg/0.5ml (human chorionic gonadotropin)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Crinone® 8% vaginal gel (progesterone)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Endometrin® 100mg vaginal insert (progesterone)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Prometrium® 100mg capsule (progesterone)	Directions: _____	Quantity: _____	Refills: _____
<input type="checkbox"/> Progesterone in oil 50mg/ml 10ml vial (progesterone in sesame oil)	Directions: _____	Quantity: _____	Refills: _____

If Brand required "Dispense as Written" must be handwritten

Prescriber Signature: X _____ **Date:** _____

Patient Name: _____ **Patient Date of Birth:** _____
Prescriber Name: _____ **Phone:** _____ **Date:** _____
Prescriber Address: _____

- Delestrogen®** (estradiol valerate for injection) 10mg/ml 20mg/ml 40mg/ml
Directions: _____ Quantity: _____ Refills: _____
- Azithromycin tablet** 250mg 500mg
Directions: _____ Quantity: _____ Refills: _____
- Letrozole 2.5mg tablet**
Directions: _____ Quantity: _____ Refills: _____
- Climara® 0.1mg/24hr patch** (estradiol transdermal)
Directions: _____ Quantity: _____ Refills: _____
- Minivelle® 0.1mg/24hr patch** (estradiol transdermal)
Directions: _____ Quantity: _____ Refills: _____
- Vivelle DOT® 0.1mg/24hr patch** (estradiol transdermal)
Directions: _____ Quantity: _____ Refills: _____
- Other:** _____ Directions: _____ Quantity: _____ Refills: _____
- Other:** _____ Directions: _____ Quantity: _____ Refills: _____

If Brand required "Dispense as Written" must be handwritten

Prescriber Signature: X _____ **Date:** _____

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Fertility Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

Patient Name: _____ Patient Date of Birth: _____
Prescriber Name: _____ Phone: _____ Date: _____
Prescriber Address: _____

Table with 3 columns: Item, Directions, Quantity, Refills. Includes checkboxes for Syringe and Needle options. Includes a signature line and a date line. Includes a box for handwritten dispensing instructions.

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