elixir
SPECIALTY PHARMACY

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

☐ **New to Therapy**
☐ **Current Therapy**

Patient 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:_____

Prescriber Information

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: ☐**Patient** ☐**Prescriber**
☐**Other**_____
Shipment Address: _____ Attn: _____
City: _____State: _____Zip:_____
If shipped to the physician's office, physician accepts on behalf of patient for administration in office.

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

Prescriber Address: _____

Prescription Information

☐ **Cetrotide® 0.25mg Syringe** Directions:_____ Quantity:_____ Refills:_____

☐ **Ganirelix® 250mcg/0.5ml Syringe** Directions:_____ Quantity:_____ Refills:_____

☐ **Leuprolide® 2-week kit** Directions:_____ Quantity:_____Refills:_____

☐ **Follistim AQ®** (follitropin) ☐ **300IU cartridge** ☐ **600IU cartridge** ☐ **900IU cartridge**
Directions:_____ Quantity:_____Refills:_____

☐ **Follistim Pen device** (Reusable and only needed for first shipment of medication)

☐ **Gonal-F®** ☐ **450IU MDV** ☐ **1050IU MDV**
Directions:_____ Quantity:_____Refills:_____

☐ **Gonal-f RFF® Rediject pen** ☒ **300IU** ☐ **450IU** ☐ **900IU**
Directions:_____ Quantity:_____Refills:_____

If Brand required "Dispense as Written" must be handwritten

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

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Prescriber Address: _____

☐ **Menopur® 75IU vial** (menotropins) Directions:_____ Quantity:_____Refills:_____

☐ **HCG® 10,000 unit vial** (human chorionic gonadotropin)

Directions:_____ Quantity:_____Refills:_____

☐ **Novarel® 5,000 unit vial** (human chorionic gonadotropin)

Directions:_____ Quantity:_____Refills:_____

☐ **Pregnyl® 10,000 unit vial** (human chorionic gonadotropin)

Directions:_____ Quantity:_____Refills:_____

☐ **Ovidrel® 250mcg/0.5ml (**human chorionic gonadotropin)

Directions:_____ Quantity:_____Refills:_____

☐ **Crinone® 8% vaginal gel (**progesterone)

Directions:_____ Quantity:_____Refills:_____

☐ **Endometrin® 100mg vaginal insert (**progesterone)

Directions:_____ Quantity:_____Refills:_____

☐ **Prometrium® 100mg capsule** (progesterone)

Directions:_____ Quantity:_____Refills:_____

☐ **Progesterone in oil 50mg/ml 10ml vial (**progesterone in sesame oil**)**

Directions:_____ Quantity:_____Refills:_____

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☐ **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:_____

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

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Prescriber Address: _____

☐ **Syringe only 1ml**	Directions:_____	Quantity:_____	Refills:_____
☐ **Syringe only 3ml**	Directions:_____	Quantity:_____	Refills:_____
☐ **Syringe 3ml 18G 1.5”**	Directions:_____	Quantity:_____	Refills:_____
☐ **Syringe 3ml 22G 1.5”**	Directions:_____	Quantity:_____	Refills:_____
☐ **Needle 18G 1.5”**	Directions:_____	Quantity:_____	Refills:_____
☐ **Needle 22G 1.5”**	Directions:_____	Quantity:_____	Refills:_____
☐ **Needle 25G 5/8”**	Directions:_____	Quantity:_____	Refills:_____
☐ **Needle 30G ½”**	Directions:_____	Quantity:_____	Refills:_____

If Brand required “Dispense as Written” must be handwritten

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