



Fertility Phone: 877-358-9016  
 Fax: 877-546-5780

# Infertility Enrollment Form

Specialty Pharmacy Enrollment Form

Please detach before submitting to a pharmacy – tear here.

## 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

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Leuprolide Two Week Kit <input type="checkbox"/> (10) Extra 1/2cc Insulin Syringes	<input type="checkbox"/> 1 mg/0.2 mL	Sig: _____		
<input type="checkbox"/> Follistim AQ Cartridge <input type="checkbox"/> PEN	<input type="checkbox"/> 300 IU <input type="checkbox"/> 600 IU <input type="checkbox"/> 900 IU	Inject as directed. <Up to _____ units per day>		
<input type="checkbox"/> Gonal-f RFF	Pen: <input type="checkbox"/> 300 IU <input type="checkbox"/> 450 IU <input type="checkbox"/> 900 IU	Inject as directed. <Up to _____ units per day>		
<input type="checkbox"/> Gonal-f	MDV: <input type="checkbox"/> 450 IU <input type="checkbox"/> 1050 IU	Inject as directed. <Up to _____ units per day>		
<input type="checkbox"/> Menopur	<input type="checkbox"/> 75 IU	Inject as directed. <Up to _____ units per day>		
<input type="checkbox"/> Ganirelix PFS	<input type="checkbox"/> 250 mcg/0.5 mL	Inject # _____ PFS SQ QD		
<input type="checkbox"/> Cetrotide Kit	<input type="checkbox"/> 0.25mg	Mix & Inject # _____ SQ QD		
<input type="checkbox"/> Pregnyl	<input type="checkbox"/> 10,000 IU	Mix with _____ mL and inject _____ units/mL when directed (IM) (SQ)		
<input type="checkbox"/> Novarel	<input type="checkbox"/> 5,000 IU	Mix with _____ mL and inject _____ units/mL when directed (IM) (SQ)		
<input type="checkbox"/> Ovidrel PFS	<input type="checkbox"/> 250 mcg/0.5 mL	Inject # _____ PFS when directed		
<input type="checkbox"/> Estrace Tablets	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg	Titrate up to _____ tab(s) per day as directed <input type="checkbox"/> PO <input type="checkbox"/> PV		
<input type="checkbox"/> Vivelle Dot	<input type="checkbox"/> 0.1mg/24 hr (#8/Box)	Use as directed up to # _____ patch(es) every _____ day(s)		
<input type="checkbox"/> Doxycycline Capsules	<input type="checkbox"/> 100mg	Take 1 capsule by mouth BID		
<input type="checkbox"/> Medrol Tablets	<input type="checkbox"/> 4mg <input type="checkbox"/> 8mg <input type="checkbox"/> 16mg	Take _____ tab(s) _____ times a day for _____ day(s)		
<input type="checkbox"/> Progesterone 50mg/mL in Sesame Oil	<input type="checkbox"/> Indicate here if Compound Ethyl Oleate is required	Inject _____ mL(s) _____ times a day		
<input type="checkbox"/> Endometrin Vaginal Inserts	<input type="checkbox"/> 100mg	Use 1 insert PV _____ times a day		
<input type="checkbox"/> Crinone 8%		Use 1 appl PV _____ times a day		
<input type="checkbox"/> Progesterone Capsules	<input type="checkbox"/> 100mg <input type="checkbox"/> 200mg	Use _____ cap(s) (PO / PV) _____ times a day		
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				
<input type="checkbox"/> Other				

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

Faxed by: \_\_\_\_\_  Donor  I.P.  G.C.

**\*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 (Product will be substituted if DAW not indicated)  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_ Supervising Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Electronic or digital signatures not accepted.

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