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. — **This form is not a valid prescription in Arizona**

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
☐ Leuprolide Two Week Kit ☐ (10) Extra ½cc Insulin Syringes	☐ 1 mg/0.2 mL	Sig: ______		
☐ Follistim AQ Cartridge ☐ PEN	☐ 300 IU ☐ 600 IU ☐ 900 IU	Inject as directed. <Up to ______ units per day>		
☐ Gonal-f RFF	Pen: ☐ 300 IU ☐ 450 IU ☐ 900 IU	Inject as directed. <Up to ______ units per day>		
☐ Gonal-f	MDV: ☐ 450 IU ☐ 1050 IU	Inject as directed. <Up to ______ units per day>		
☐ Menopur	☐ 75 IU	Inject as directed. <Up to ______ units per day>		
☐ Ganirelix PFS	☐ 250 mcg/0.5 mL	Inject #______ PFS SQ QD		
☐ Cetrotide Kit	☐ 0.25mg	Mix & Inject #______ SQ QD		
☐ Pregnyl	☐ 10,000 IU	Mix with ______ mL and inject ______ units/mL when directed (IM) (SQ)		
☐ 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		
☐ Estrace Tablets	☐ 0.5mg ☐ 1mg ☐ 2mg	Titrate up to ______ tab(s) per day as directed ☐ PO ☐ PV		
☐ Vivelle Dot	☐ 0.1mg/24 hr (#8/Box)	Use as directed up to # ______ patch(es) every ______ day(s)		
☐ Doxycycline Capsules	☐ 100mg	Take 1 capsule by mouth BID		
☐ Medrol Tablets	☐ 4mg ☐ 8mg ☐ 16mg	Take ______ tab(s) ______ times a day for ______ day(s)		
☐ Progesterone 50mg/mL in Sesame Oil	☐ Indicate here if Compound Ethyl Oleate is required	Inject ______ mL(s) ______ times a day		
☐ Endometrin Vaginal Inserts	☐ 100mg	Use 1 insert PV ______ times a day		
☐ Crinone 8%		Use 1 appl PV ______ times a day		
☐ Progesterone Capsules	☐ 100mg ☐ 200mg	Use ______ cap(s) (PO / PV) ______ times a day		
☐ Other				
☐ Other				
☐ 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.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone. This form is not a valid prescription in Arizona.