Tel 718 484 8510

Date: __________ Needs by Date: ___________

Specialty Fertility Pharmacy Enrollment Form

Fax 718 484 8508

Ship to: Patient Office Other:

PATIENT INFORMATION

(Complete the following or ***send patient demographic sheet****)*

Patient Name: ____________________

Address: ____________________

City, State, Zip: ____________________

Home Phone: ____________________

Alternate Phone: ____________________

SS #: ____________________

Date of Birth: Gender:

PRESCRIBER INFORMATION

Prescriber's Name: ____________________

State License #: __________ UPIN: __________

DEA #: __________ NPI #: __________

Group or Hospital: ____________________

Address: ____________________

City, State Zip: ____________________

Phone: __________ Fax: __________

Contact Person: Phone:

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

Primary Insurance Subscriber __________ ID # __________ Name of Insurer; __________ Phone __________

Secondary Insurance Subscriber __________ ID # __________ Name of Insurer; __________ Phone __________

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-9

____

Other Medications:

Current Medication List __________

Dosage __________________

Strength ____________________

Other Clinical

- Weight: _______kg/lb • Height: _______inches • BSA: _______ m^2
- Comments/Allergies/Previous ____________________
- Concomitant Medications: warfarin Other: ____________________

Revlimid®-RevAssist • Physician Auth#: ______________

Thalomid®-STEPS • Pharmacy Conf #:______________ Date:________

Revlimid® Pregnancy

Adult Female – NOT of Childbearing Potential

Adult Female – Childbearing Potential

Adult Male Male Child

Female Child – NOT of Childbearing Potential

Female Child – Childbearing Potential

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS/SIG	QTY	REFILL	MEDICATION	STRENGTH	DIRECTIONS/SIG	QTY	REFILL
Ganirelix Acetate	250mcg/0.5ml syringe				Progesterone in oil	50mg/ml vial			
Cetrotide	0.25mg kit 3mg kit				Progesterone in Cottonseed oil	50mg/ml vial			
Leuprolide Acetate	2-week kit				Progesterone in Olive oil	50mg/ml vial			
Lupron (DAW)	2-week kit				3cc 18g 1.5" Syringe, 22g 1.5" Needle				
Insulin Syringe	0.5cc				Progesterone	____mg caps			
Microdose Leuprolide	50mcg/0.1ml 10ml vial				Progesterone suppositories	____mg			
Insulin Syringe	0.5cc				Crinone 8%	15 appl (26.1GM)			
Bravelle	75 unit vial				Endometrin	100mg			
Menopur	75 unit vial				Vivelle Dot	____mg patches			
Repronex	75 unit vial				Estraderm	____mg patches			
Q-Cap IM (3cc syringe only, 25g 1.5" needle)					Estrace	____mg tabs			
Q-Cap SubQ (3cc syringe only, 27g 0.5" needle)					Femtrace	____mg			
Follistim	75 unit AQ vial				Clomiphene Citrate	50mg tabs			
Follistim	150 unit AQ vial				Methylprednisolone	______mg			
Follistim	300 unit AQ Cartridge				Doxycycline	100mg tabs			
Follistim	600 unit AQ Cartridge				Baby Aspirin	81mg tabs			
Follistim	900 unit AQ Cartridge				Birth Control				
Follistim Pen					Prenatal Vitamin				
Gonal-f RFF	75 unit vial				Folic Acid	1mg tabs			
Gonal-f RFF	300 unit pen				IM (3cc22g1.5" syringe, 25g 1.5" needle)				
Gonal-f RFF	450 unit pen				SubQ (3cc22g1.5" syringe, 27g 0.5"needle)				
Gonal-f RFF	900 unit pen								
Gonal-f RFF	450 unit MDV								
Luveris	75 unit vial								
HCG	10,000 unit vial								
Novarel	10,000 unit vial								
Ovidrel	250mcg syringe								
Pregnyl	10,000 unit vial								
Low Dose HCG					Sharps container				
Insulin Syringe	0.5cc				Patient Edu.				

Any known allergies? Yes No List: ____________________

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.

Prescriber's Signature Required: ----> ____________________