

Optum specialty phone: 877-358-9016 Optum specialty fax: 844-234-1361

Infertility Enrollment Form

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Specialty pharmacy enrollment form

Please detach before submitting to a pharmacy - tear here.

This form is not a valid prescription in Arizona and Virginia

PATIENT INFORMATION		PRESCRIBER INFORMATION	PRESCRIBER INFORMATION			
Patient Name Address City, State, ZIP Home Phone DOB Last Fo Language Preference:Englis	r send patient demographic sheet Alternate Phone pur of SS# Gender shSpanishOther	DEA NPI Address City, State, ZIP Phone Fax Fax Office Contact Fax City and the state of the state				
INSURANCE INFOR	MATION (Must fax a copy of patier	nt's insurance card including both sides)				
Plan Name		Prior Authorization Reference Number				
BIN PCN	Group	Cardholder ID				
MEDICAL INFORM	ATION (Section must be comp	leted to process prescription) (Attach separate sheet if needed	l)			
Diagnosis - Please include diag						
ICD-10 Code	Description .					
Allergies		Concomitant Medications				
PRESCRIPTION INFO	ORMATION					
Medication	Dose/Strength	Directions	Quantity	Refills		
Leuprolide Two Week Kit	1 mg/0.2 mL	Sig:				
Follistim AQ Cartridge	300 IN 600 IN 900 IN	Inject units SQ QD as directed				
Gonal-f RFF	Pen: 300 IU 450 IU 900 IU	Inject units SQ QD as directed				

Pen: 300 IU 450 IU 900 IU	Inject units SQ QD as directed		
MDV: 450 IU 1050 IU	Mix and inject units SQ QD as directed		
□75 IU	Mix and inject units SQ QD as directed		
250 mcg/0.5 mL	Inject 1 PFS SQ QD		
0.25mg	Mix and inject 0.25mg SQ QD		
10,000 IU	Mix with mL and inject units/mL [] IM [] SQ		
□5,000 IU	Mix with mL and inject units/mL 🗌 IM 🔲 SQ		
250 mcg/0.5 mL	Inject # PFS when directed		
0.5mg 1mg 2mg	Take tab(s) times a day as directed PO PV		
0.1mg/24 hr (#8/Box)	Use as directed up to # patch(es) every day(s)		
100mg	Take 1 capsule by mouth BID		
□4mg □8mg □16mg	Taketab(s) POtimes a day		
	MDV: 450 IU 1050 IU 75 IU 1050 IU 250 mcg/0.5 mL 0.25mg 10,000 IU 5,000 IU 250 mcg/0.5 mL 0.5mg 0.5mg 1mg 20.5mg 1001mg/24 hr (#8/Box)	MDV: 450 IU 1050 IU Mix and inject units SQ QD as directed 75 IU Mix and inject units SQ QD as directed 250 mcg/0.5 mL Inject 1 PFS SQ QD 0.25mg Mix and inject 0.25mg SQ QD 10,000 IU Mix with mL and inject units/mLIMSQ 250 mcg/0.5 mL Inject # PFS when directed 250 mcg/0.5 mL Inject # PFS when directed 0.05mg 1mg2mg Take tab(s) times a day as directed PO V 0.1mg/24 hr (#8/Box) Use as directed up to # patch(es) every day(s) 100mg Take 1 capsule by mouth BID	MDV: 450 IU 1050 IU Mix and inject units SQ QD as directed 75 IU Mix and inject units SQ QD as directed Image: Constraint of the system of the s

• Prescriber Authorization: I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. 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.

Ship to: Patient Office Oth	er	Date: Needs	by date:
Faxed by: Donor I.P. G.C.			
Dispense as Written Substitution Permitted			itution Permitted
Prescriber's		Prescriber's	
Signature	Date	_ Signature	Date
Electronic or digital signatures not accepted. Electronic or digital signatures not accepted.			
Supervising/Collaborative Physician Information (per state requirements)			

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 and Virginia.



Endometrin Vaginal Inserts

Progesterone Capsules

Crinone 8%

Other Other Other

100mg

100mg 200mg

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		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 diagnosi	s name with ICD-10 code			
ICD-10 Code	Description _			
Allergies		Concomitant Medications		
PRESCRIPTION INFOR	MATION			
Medication	Dose/Strength	Directions	Quantity	Refills
Progesterone 50mg/mL in Sesame Oil	Indicate here if Compound Olive Oil	Inject mL IM times a day		

Use 1 insert PV _____ times a day

Use 1 appl PV _____ times a day

____ cap(s) PO_____times a day

___ times a day

Use_

PV_

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Ship to: Patient Office Other		Date: Needs	s by date:
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Dispense as Written Substitution Permitted			itution Permitted
Prescriber's		Prescriber's	
Signature	Date	Signature	Date
Electronic or digital signatures not accepted.		Electronic or digital signatures not accepted.	
Supervising/Collaborative Physician Information (per state requirements)			

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