

Fertility Phone: 877-358-9016

Fax: 844-234-1361

Infertility Enrollment Form

PRESCRIPTION INFORMATION PRESCRIPTION PRESCRI	Specialty Pharmacy Enrollment Fol		before submitting to a pharmacy – tear here.	Prescription	
Prescribers Name	PATIENT INFORMATION		PRESCRIBER INFORMATION		
DEA	Please complete the following or se	end patient demographic sheet	Proscriber's Name		
Address City, State 2P City, State 2	Patient Name				
City, State, 2P	Address				
Dispute	City, State, ZIP		Address		
Comparison Com	Home Phone	Alternate Phone	City, State, ZIP		
Diffice Contact Prior Authorization Office	DOB Last Four of	of SS# Gender	Phone Fax		
Procedure Proc	<u> </u>	_			
Prior Authorization Reference Number Prov. Group Cardholder ID					
MEDICAL INFORMATION (Section must be completed to process prescription) (Attoch separate sheet if needed)			-		
MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed:) Diagnosts - Please include diagnosis name with ICD-10 code	Plan Name		Prior Authorization Reference Number		
Depart D	BIN PCN	Group	Cardholder ID		
Allergies	MEDICAL INFORMATIO	N (Section must be compl	eted to process prescription) (Attach separate sheet if need	ded)	
PRESCRIPTION INFORMATION Medication	Diagnosis – Please include diagnos	sis name with ICD-10 code			
PRESCRIPTION INFORMATION Medication Dose/Strength Directions Quantity Refills	ICD-10 Code	Description			
Leuprolide Two Week kit 1 mg/0.2 mL Sig:	Allergies		Concomitant Medications		
Lauprolide Two Week Kit 100 Extra loce Insulin Syringes Follistim Act Cel Insul	PRESCRIPTION INFORI	MATION			
Tinglot Michael Noce Insulin Syringes Tinglot Noce Insulin Syringes Ting	Medication	Dose/Strength	Directions	Quantity	Refills
Foliatin AQ Cartridge	:	☐1 mg/0.2 mL	Sig:		
Gonal-f	Follistim AQ Cartridge	□ 300 IU □ 600 IU □ 900 IU			
Menopur		Pen: 300 IU 450 IU 900 IU	Inject as directed. <up day="" per="" to="" units=""></up>		-
Ganirelix PFS	☐ Gonal-f	MDV: 450 IU 1050 IU	Inject as directed. <up day="" per="" to="" units=""></up>		
Cetrotide Kit	Menopur	☐ 75 IU	Inject as directed. <up day="" per="" to="" units=""></up>		
Cetrotide Kit	Ganirelix PFS	250 mcg/0.5 mL	Inject # PFS SQ QD		
Novarel 5,000 IU Mix withmL and injectunits/mL when directed (IM) (SQ)	Cetrotide Kit	 	Mix & Inject # SQ QD		
Ovidrel PFS	Pregnyl	□10,000 IU	Mix with mL and inject units/mL when directed (IM) (SQ)		
Estrace Tablets 0.5mg Ing 2mg Titrate up totab(s) per day as directed PO PV	Novarel	□ 5,000 IU	Mix with mL and inject units/mL when directed (IM) (SQ)		
Vivelle Dot O.1mg/24 hr (#8/Box) Use as directed up to #patch(es) everyday(s)	Ovidrel PFS	250 mcg/0.5 mL	Inject # PFS when directed		
Doxycycline Capsules 100mg Take 1 capsule by mouth BID	Estrace Tablets	□ 0.5mg □ 1mg □ 2mg	Titrate up to tab(s) per day as directed PO PV		
Medrol Tablets	☐ Vivelle Dot	0.1mg/24 hr (#8/Box)	Use as directed up to # patch(es) every day(s)		
Progesterone 50mg/mL in	Doxycycline Capsules	☐ 100mg	Take 1 capsule by mouth BID		
Sesame Oil Oleate is required Inject	Medrol Tablets	☐ 4mg ☐ 8mg ☐ 16mg	Take tab(s) times a day for day(s)		
Crinone 8% Use 1 appl PVtimes a day			Inject mL(s) times a day		
Progesterone Capsules 100mg 200mg Use cap(s) (PO / PV) times a day Other	Endometrin Vaginal Inserts	□100mg	Use 1 insert PV times a day		
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) Prescriber's Supervising Physician Signature Date Date Date Date Date Date	Crinone 8%		Use 1 appl PV times a day		
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 Supervising Physician Signature Date Date Date Date	Progesterone Capsules	□ 100mg □ 200mg	Use cap(s) (PO / PV) times a day		
Other Ship to: Patient Office Other	Other				
Ship to: Patient Office Other	Other				
Faxed by:	Other				
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) Prescriber's Supervising Physician Signature Date Date Date Date		Other			
Substituted if DAW not indicated) Prescriber's Signature Date Date Date Date Date Date	behalf as my authorized agent, including the recei this prescription, I further authorize this pharmacy	ipt of any required prior authorization forms and the re to forward this information and any related materials Product will be	eceipt and submission of patient lab values and other patient data. In the event that this pharmacy determ related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's	ines that it is unable	
Signature Date Date Date	substituted if DAW not indicated	I IIIIspense as Wi	Supervising		
en in the contract of the cont		Date	Physician Signature	_ Date	
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