OPTUM®

Fertility Phone: 877-358-9016
Fax: 844-234-1361

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.