

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

Note: This form is intended for prescriber use only, if faxed, the fax must come from MD office or hospital (may not be faxed by patient).

Prescription/Pharmacy Intake Form

For office use only

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Anticipated Start Date (REQUIRED): \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Allergies: \_\_\_\_\_

Address: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

ICD-10: \_\_\_\_\_ Cycle#: \_\_\_\_\_ Cycle Type:  IUI  IVF  FET Insurance  : Copy of card (front and back)

Desogen  Other: \_\_\_\_\_ Qty (Packs) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

leuprolide acetate 1mg/0.2ml - 2 week kit - 14mg/2.8ml MDV Qty (Kits) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Microdose leuprolide acetate 5ml MDV (compounded\*)  
 20mcg/0.1ml \_\_\_\_\_ Qty (Kits) \_\_\_\_\_  
 40mcg/0.1ml \_\_\_\_\_ Qty (Kits) \_\_\_\_\_  
 50mcg/0.1ml \_\_\_\_\_ Qty (Kits) \_\_\_\_\_

# \_\_\_ 0.5ml Insulin Syringes \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Leuprolide acetate Trigger (PFS) (compounded\*)  
 1 MG/0.2mL (=20 units) \_\_\_\_\_ Qty (PFS) \_\_\_\_\_  
 2 MG/0.4mL (=40 units) \_\_\_\_\_ Qty (PFS) \_\_\_\_\_  
 4 MG/0.8mL (=80 units) \_\_\_\_\_ Qty (PFS) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Ganirelix 250 mcg/0.5mL Injection \_\_\_\_\_ Qty \_\_\_\_\_  
 Fyremadel 250 mcg/0.5mL Injection \_\_\_\_\_ Qty \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Cetrotide 0.25mg \_\_\_\_\_ Qty (Kits) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Follistim AQ Cartridge  Follistim Pen  
 300 International Units \_\_\_\_\_ Qty \_\_\_\_\_  
 600 International Units \_\_\_\_\_ Qty \_\_\_\_\_  
 900 International Units \_\_\_\_\_ Qty \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Gonal-f RFF Redi-ject  
 300 International Units \_\_\_\_\_ Qty \_\_\_\_\_  
 450 International Units \_\_\_\_\_ Qty \_\_\_\_\_  
 900 International Units \_\_\_\_\_ Qty \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Gonal-f Multi-Dose 450 International Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 Gonal-f Multi-Dose 1050 International Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 Gonal-f RFF 75 International Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Menopur 75 International Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 # \_\_\_ 3ml 22g 1 1/2" syringes/needles  # \_\_\_ g \_\_\_ " needles \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Ovidrel 250mcg Prefilled Syringes \_\_\_\_\_ Qty (PFS) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Micro HCG ALFA 2.5mcg/0.1ml per 2ml MDV (compounded\*) \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 # \_\_\_ 0.5ml Insulin Syringes \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Low Dose HCG 5ml MDV (compounded\*) \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 10 USP Units/0.1ml \_\_\_\_\_  
 # \_\_\_ 0.5ml Insulin Syringes \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

HCG 10,000 USP Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 Novarel 5,000 USP Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 Pregnyl 10,000 USP Units \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 # \_\_\_ 3ml 22g 1 1/2" syringes/needles  # \_\_\_ g \_\_\_ " needles \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Crinone 8% Gel - 15 applicators per box \_\_\_\_\_ Qty (Applicators) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Endometrin Vaginal Insert 100mg \_\_\_\_\_ Qty (Tabs) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Progesterone in Sesame Oil 50mg/ml 10ml Vial \_\_\_\_\_ Qty (Vials) \_\_\_\_\_  
 # \_\_\_ 3ml 18g 1 1/2" needle  # \_\_\_ 22g 1 1/2" needles \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Progesterone Suppositories (compounded)  
 25mg \_\_\_\_\_ Qty (Supps) \_\_\_\_\_  
 50mg \_\_\_\_\_ Qty (Supps) \_\_\_\_\_  
 100mg \_\_\_\_\_ Qty (Supps) \_\_\_\_\_  
 200mg \_\_\_\_\_ Qty (Supps) \_\_\_\_\_  
 300mg \_\_\_\_\_ Qty (Supps) \_\_\_\_\_  
 400mg \_\_\_\_\_ Qty (Supps) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Prometrium  100mg  200mg \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Progesterone capsules (compounded)  
 50mg \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
 100mg\*\* \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
 200mg\*\* \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
 300mg \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
 400mg \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_  
\*\*For vaginal use or peanut allergy only

Methylprednisolone \_\_\_mg \_\_\_\_\_ Qty (Tabs) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Doxycycline 100mg \_\_\_\_\_ Qty (Caps) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Clomiphene Citrate 50mg \_\_\_\_\_ Qty (Tabs) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Estradiol  
 1mg \_\_\_\_\_ Qty (Tabs) \_\_\_\_\_  
 2mg \_\_\_\_\_ Qty (Tabs) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Minivelle \_\_\_\_\_ Qty (Patches) \_\_\_\_\_  
 Vivelle \_\_\_\_\_ Qty (Patches) \_\_\_\_\_  
 Climara \_\_\_\_\_ Qty (Patches) \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

Other: \_\_\_\_\_ Qty \_\_\_\_\_  
Sig.: \_\_\_\_\_ (= \_\_\_ days) \_\_\_\_\_ Refills \_\_\_\_\_

FILL TOTAL PRESCRIPTION

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

Prescriber's name: \_\_\_\_\_

State license #: \_\_\_\_\_ DEA #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicaid UPIN #: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" or your state specific required language after their signature.

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

Dispense as written

Substitution permitted

Date

\*\*\* THIS FORM IS NOT VALID IN THE STATE OF ALABAMA \*\*\* The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

Drug names are the property of their respective owners.

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