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)**.

Clinic Name: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Prescription/Pharmacy Intake Form

For office use only

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 ____ Qty (Kits)
Sig.: _____ (= ___ days) ____ Refills

☐ Microdose leuprolide acetate _____mcg/_____ml 10ml vial
☐ #____ 0.5ml Insulin Syringes ____ Qty (Vials)
Sig.: _____ (= ___ days) ____ Refills

☐ Leuprolide acetate Trigger
☐ 1 MG/0.2mL ____ Qty (Vials)
☐ 2 MG/0.4mL ____ Qty (Vials)
☐ 4 MG/0.8mL ____ Qty (Vials)
Sig.: _____ (= ___ days) ____ Refills

☐ Ganirelix Acetate for Injection 250mcg ____ 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 ½" syringes/needles ☐ #____ _____g _____" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Ovidrel 250mcg Prefilled Syringes ____ Qty (PFS)
Sig.: _____ (= ___ days) ____ Refills

☐ Other: _____ ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Other: _____ ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Low Dose HCG ____ Qty (Vials)
☐ 10 International Units/0.1ml
☐ _____ International Units/_____ml
☐ #____ 0.5ml Insulin Syringes
Sig.: _____ (= ___ days) ____ Refills

☐ HCG 10,000 International Units ____ Qty (Vials)
Novarel ☐ 5,000 International Units ☐ 10,000 International Units ____ Qty (Vials)
☐ Pregnyl 10,000 International Units ____ Qty (Vials)
☐ #____ 3ml 22g 1 ½" 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 ½" needle ☐ #____ 22g 1 ½" needles
Sig.: _____ (= ___ days) ____ Refills

☐ Progesterone Suppositories _____mg ____ Qty
Sig.: _____ (= ___ days) ____ Refills

☐ Prometrium _____mg ____ Qty (Caps)
Sig.: _____ (= ___ days) ____ Refills

☐ Progesterone capsules (compounded)
☐ 50mg ____ Qty (Caps)
☐ 300mg ____ Qty (Caps)
☐ 400mg ____ Qty (Caps)
Sig.: _____ (= ___ days) ____ Refills

☐ 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

☐ Estradiol Patch _____mg ____ Qty (Patches)
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

City, State

Phone: 123-123-1234

Fax: 123-123-1234