

**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 \_\_\_\_\_ 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 1/2" 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 \_\_\_\_\_ Refills  
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 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 \_\_\_\_\_ 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

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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