FERTILITY ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient: _____ Caregiver: _____

DOB: _____ ☐ Male ☐ Female Weight: _____ ☐ kgs or ☐ lbs (check one) Height: _____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies: _____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Has patient tried and failed Clomiphene Citrate? ☐ Yes ☐ No If yes, how many cycles did patient complete? _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Ganirelix Acetate	250mcg/ 0.5mL syringe		____	
☐ Cetrotide	☐ 0.25mg kit ☐ 3mg kit		____	
☐ Leuprolide Acetate	2-week kit		____	
☐ Bravelle	75 unit vial		____	
☐ Menopur	75 unit vial		____	
☐ Repronex	75 unit vial		____	
☐ Follistim	☐ 150 unit AQ vial ☐ 300 unit AQ Cartridge ☐ 600 unit AQ Cartridge ☐ 900 unit AQ Cartridge		____ ____ ____ ____	
Follistim Pen				
Doxycycline Hyclate	100mg tablet			
Vivelle Dot	_____ mg patches			
Baby Aspirin	81mg tabs			
Prenatal Vitamin				
HCG DEA# _____	10,000 unit vial			
Ovidrel DEA# _____	250mcg syringe			

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Progesterone in oil (Sesame oil)	50mg/mL vial			
☐ Progesterone	_____ mg caps			____
☐ Crinone 8%	15 appl (26.1GM)			____
☐ Endometrin	100mg			____
Estradiol	_____ mg tabs			____
Clomiphene Citrate	50mg tabs			____
☐ Gonal-f RFF	☐ 75 unit vial ☐ 300 unit pen ☐ 450 unit pen ☐ 900 unit pen ☐ 450 unit MDV ☐ 1050 unit MDV			____ ____ ____ ____ ____ ____
	_____ mg			
Birth Control				
Folic Acid	1mg tabs			
Novarel	10,000 unit vial			
Pregnyl	10,000 unit vial			
Other				

SUPPLIES

Syringes	QTY		QTY
3cc 18g 1.5”	_____	22g 1.5”	_____
3cc 22g 1.5”	_____	27G .5”	_____
3cc	_____		
Insulin syringe ☐ cc ☐ G ☐ inch	_____	25G 1.5”	_____

Syringes	QTY
Sharps	
Other	

INJECTION TRAINING: OFFICE TO COORDINATE HEALTHDYNE SPECIALTY TO COORDINATE

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other: _____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber’s Name: _____ Prescriber’s Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as written