



**PHARMACY SERVICES ENROLLMENT FORM**

For Office Use Only

Rx FAX to:  
**1-718-762-7404**

Rx Phone:  
**1-718-762-7400**

Clinic:  
Address:  
City, State, Zip:  
Phone:

Fax:

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

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

Indicate priority with a number 1, 2, and 3 in check box.

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

ICD9- \_\_\_\_\_ Cycle#: \_\_\_\_\_ Cycle Type: ☐ IUI ☐ IVF ☐ FET Insurance ☐ : Copy of card (front and back)

<input type="checkbox"/> Desogen® <input type="checkbox"/> Mircette® Sig.: _____ (= ____ days) _____ Qty (Packs) _____ Refills	<input type="checkbox"/> Low Dose HCG <input type="checkbox"/> 10 International Units /ml <input type="checkbox"/> 20 International Units /ml <input type="checkbox"/> 1ml Insulin Syringes # _____ Qty (Vials)
<input type="checkbox"/> Leuprolide Acetate 1mg/0.2ml – 2 Week Kit Sig.: _____ (= ____ days) _____ Qty (Kits) _____ Refills	Sig.: _____ (= ____ days) _____ Refills
<input type="checkbox"/> Microdose Leuprolide Acetate _____ mcg/ _____ ml 5ml Vial <input type="checkbox"/> ½ml Insulin Syringes # _____ Qty (Vials) Sig.: _____ (= ____ days) _____ Refills	<input type="checkbox"/> HCG 10,000 International Units <input type="checkbox"/> Novarel® 10,000 International Units <input type="checkbox"/> Pregnyl® 10,000 International Units _____ Qty (Vials) <input type="checkbox"/> # _____ 3ml 22g 1 ½" syringes/needles # _____ g _____ " needles Sig.: _____ (= ____ days) _____ Refills
<input type="checkbox"/> Lupron Depot® _____ mg Sig.: _____ (= ____ days) _____ Qty _____ Refills	<input type="checkbox"/> Crinone® 8% Gel – 15 per box _____ Qty _____ Refills
<input type="checkbox"/> Ganirelix Acetate for Injection 250mcg Sig.: _____ (= ____ days) _____ Qty _____ Refills	<input type="checkbox"/> Endometrin® Vaginal Tablet 100mg _____ Qty _____ Refills
<input type="checkbox"/> Cetrotide® <input type="checkbox"/> 0.25mg <input type="checkbox"/> 3mg Sig.: _____ (= ____ days) _____ Qty (Kits) _____ Refills	<input type="checkbox"/> Ovidrel® 250mcg Prefilled Syringes _____ Qty _____ Refills
<input type="checkbox"/> Follistim® AQ Cartridge <input type="checkbox"/> Follistim Pen® QTY: _____ 300 _____ 600 _____ 900 International Units Sig.: _____ (= ____ days) _____ Refills <input type="checkbox"/> Follistim® 75 International Units _____ Qty (Vials) <input type="checkbox"/> Follistim® 150 International Units _____ Qty (Vials) <input type="checkbox"/> # _____ 3ml 22g 1 ½" syringes/needles # _____ g _____ " needles	<input type="checkbox"/> Progesterone in Oil-50mg/ml 10ml Vial _____ Qty <input type="checkbox"/> Progesterone in Ethyl Oleate 50mg/ml 10ml Vial _____ Qty <b>draw:</b> 3 cc 18g 1 ½" needle # _____ <b>inj:</b> 22 g 1 ½" needle # _____ Sig.: _____ (= ____ days) _____ Refills <input type="checkbox"/> Progesterone Suppositories _____ mg _____ Qty Sig.: _____ (= ____ days) _____ Refills
<input type="checkbox"/> Gonal-f® RFF Pen Qty: _____ 300 _____ 450 _____ 900 International Units Sig.: _____ (= ____ days) _____ Refills <input type="checkbox"/> Gonal-f® 450 International Units Multidose _____ Qty (Vials) <input type="checkbox"/> Gonal-f® 1050 International Units Multidose _____ Qty (Vials) <input type="checkbox"/> Gonal-f® RFF 75 International Units _____ Qty (Vials) Sig.: _____ (= ____ days) _____ Refills	<input type="checkbox"/> Prometrium® 200mg capsules _____ Qty _____ Refills <input type="checkbox"/> Medrol® _____ mg tablets _____ Qty _____ Refills <input type="checkbox"/> Doxycycline 100mg capsules _____ Qty _____ Refills
<input type="checkbox"/> Repronex® 75 International Units <input type="checkbox"/> IM <input type="checkbox"/> SC _____ Qty (Vials) <input type="checkbox"/> # _____ 3ml 22g 1 ½" syringes/needles # _____ g _____ " needles Sig.: _____ (= ____ days) _____ Refills	<input type="checkbox"/> Clomid® 50mg <input type="checkbox"/> Clomiphene Citrate 50mg _____ Qty _____ Refills <input type="checkbox"/> Estrace® <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg tablets _____ Qty _____ Refills
<input type="checkbox"/> Menopur® 75 International Units <input type="checkbox"/> IM <input type="checkbox"/> SC _____ Qty (Vials) <input type="checkbox"/> # _____ 3ml 22g 1 ½" syringes/needles # _____ g _____ " needles Sig.: _____ (= ____ days) _____ Refills	<input type="checkbox"/> Estradiol Patch _____ mg _____ Qty _____ Refills <input type="checkbox"/> Other: _____ Qty _____ Refills Sig.: _____ (= ____ days) _____ Refills
<input type="checkbox"/> Luveris® 75 International Units <input type="checkbox"/> IM <input type="checkbox"/> SC _____ Qty (Vials) <input type="checkbox"/> # _____ 3ml 22g 1 ½" syringes/needles # _____ g _____ " needles Sig.: _____ (= ____ days) _____ Refills	<input type="checkbox"/> Other: _____ Qty _____ Refills Sig.: _____ (= ____ days) _____ Refills
<input type="checkbox"/> Other: _____ Qty _____ Refills Sig.: _____ (= ____ days) _____ Refills	<input type="checkbox"/> Other: _____ Qty _____ Refills Sig.: _____ (= ____ days) _____ Refills

☐ SCHEDULE TEACH & TOUCH, CALL RN ON DAY MEDICATION ARRIVES.

Prescriber's Signature: \_\_\_\_\_ MD DEA# \_\_\_\_\_

INTERCHANGE IS MANDATED UNLESS PRACTITIONER WRITES THE WORDS "BRAND NAME NECESSARY" IN THIS SPACE

Prescriber's Name (Print): \_\_\_\_\_

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