evers SPECIALTY PHARMACY

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)**

☐ Desogen® ☐ Mircette® ____ Qty (Packs)
Sig.: _____ **(= ___ days)** ____ Refills

☐ Leuprolide Acetate 1mg/0.2ml – 2 Week Kit ____ Qty (Kits)
Sig.: _____ **(= ___ days)** ____ Refills

☐ Microdose Leuprolide Acetate _____mcg/_____ml 5ml Vial
☐ ½ml Insulin Syringes #____ ____Qty (Vials)
Sig.: _____ **(= ___ days)** ____ Refills

☐ Lupron Depot® _____ mg ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Ganirelix Acetate for Injection 250mcg ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Cetrotide® ☐ 0.25mg ☐ 3mg ____ Qty (Kits)
Sig.: _____ **(= ___ days)** ____ Refills

☐ Follistim® AQ Cartridge
☐ Follistim Pen®
QTY: ____ 300 ____ 600 ____ 900 International Units
Sig.: _____ **(= ___ days)** ____ Refills
☐ Follistim® 75 International Units ____ Qty (Vials)
☐ Follistim® 150 International Units ____ Qty (Vials)
☐ #___ 3ml 22g 1 ½" syringes/needles #___ ___g ___" needles

☐ Gonal-f® RFF Pen Qty: ____ 300 ____ 450 ____ 900 International Units
Sig.: _____ **(= ___ days)** ____ Refills
☐ Gonal-f® 450 International Units Multidose ____ Qty (Vials)
☐ Gonal-f® 1050 International Units Multidose ____ Qty (Vials)
☐ Gonal-f® RFF 75 International Units ____ Qty (Vials)
Sig.: _____ **(= ___ days)** ____ Refills

☐ Repronex® 75 International Units ☐ **IM** ☐ **SC** ____ Qty (Vials)
☐ #___ 3ml 22g 1 ½" syringes/needles #___ ___g ___" needles
Sig.: _____ **(= ___ days)** ____ Refills

☐ Menopur® 75 International Units ☐ **IM** ☐ **SC** ____ Qty (Vials)
☐ #___ 3ml 22g 1 ½" syringes/needles #___ ___g ___" needles
Sig.: _____ **(= ___ days)** ____ Refills

☐ Luveris® 75 International Units ☐ **IM** ☐ **SC** ____ Qty (Vials)
☐ #___ 3ml 22g 1 ½" syringes/needles #___ ___g ___" needles
Sig.: _____ **(= ___ days)** ____ Refills

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

☐ Low Dose HCG ☐ 10 International Units /ml ☐ 20 International Units /ml
☐ 1ml Insulin Syringes # ____ ____Qty (Vials)
Sig.: _____ **(= ___ days)** ____ Refills

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

☐ Crinone® 8% Gel – 15 per box ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Endometrin® Vaginal Tablet 100mg ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

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

☐ Progesterone in Oil-50mg/ml 10ml Vial ____ Qty
☐ Progesterone in Ethyl Oleate 50mg/ml 10ml Vial ____ Qty
draw: 3 cc 18g 1½ " needle #___ **inj**: 22 g 1½ " needle #___
Sig.: _____ **(= ___ days)** ____ Refills
☐ Progesterone Suppositories _____ mg ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Prometrium® 200mg capsules ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Medrol® _____mg tablets ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Doxycycline 100mg capsules ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Clomid® 50mg ☐ Clomiphene Citrate 50mg ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Estrace® ☐1mg ☐ 2mg tablets ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

☐ Estradiol Patch _____mg ____ Qty
Sig.: _____ **(= ___ days)** ____ Refills

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

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

☐ Other: ____ Qty
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): _____