

National Fertility Care Program Enrollment Form

 **Express Health Mart Pharmacy**
1173 Nostrand ave, Brooklyn, NY 11225

Tel: 347-221-1100 | E-Fax: 347-221-1919
E-mail: ehmpharmacy@gmail.com | www.expresshealthmart.com

6 Simple steps to submitting a referral

1 PATIENT INFORMATION
(Complete the following or include demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Primary Phone: _____ DOB: _____
Alternate Phone: _____ Gender: Male Female
E-mail: _____
Last Four of SS #: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____ Phone: _____

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION Needs by Date: _____ Ship to: Patient Office Other: _____

628 Female Infertility Other: _____
Height: _____ Weight: _____ Allergies: _____ Has patient received injection training? Yes No
Has patient tried and failed Clomiphene Citrate? Yes No If yes, how many cycles did patient complete? _____
Anticipated Start Date: _____

5 PRESCRIPTION INFORMATION

| MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILLS | MEDICATION | DOSE/STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|------------|----------|---------|---|------------------|------------|----------|---------|
| <input type="checkbox"/> Ganirelix Acetate | 250mcg/0.5ml syringe | | | | <input type="checkbox"/> Low Dose HCG | | | | |
| <input type="checkbox"/> Cetrotide | <input type="checkbox"/> 0.25mg kit <input type="checkbox"/> 3mg kit | | | | <input type="checkbox"/> Insulin Syringe | 0.5cc | | | |
| <input type="checkbox"/> Leuprolide Acetate | 2-week kit | | | | <input type="checkbox"/> Progesterone in oil | 50mg/ml vial | | | |
| <input type="checkbox"/> Lupron (DAW) | 2-week kit | | | | <input type="checkbox"/> Progesterone in Cottonseed oil | 50mg/ml vial | | | |
| <input type="checkbox"/> Insulin Syringe | 0.5cc | | | | <input type="checkbox"/> Progesterone in Olive oil | 50mg/ml vial | | | |
| <input type="checkbox"/> Microdose Leuprolide | 50mcg/0.1ml 10ml vial | | | | <input type="checkbox"/> 3cc 18g 1.5" Syringe, 22g 1.5" Needle | | | | |
| <input type="checkbox"/> Insulin Syringe | 0.5cc | | | | <input type="checkbox"/> Progesterone | ____mg caps | | | |
| <input type="checkbox"/> Bravelle | 75 unit vial | | | | <input type="checkbox"/> Progesterone suppositories | ____mg | | | |
| <input type="checkbox"/> Menopur | 75 unit vial | | | | <input type="checkbox"/> Crinone 8% | 15 appl (26.1GM) | | | |
| <input type="checkbox"/> Repronex | 75 unit vial | | | | <input type="checkbox"/> Endometrin | 100mg | | | |
| <input type="checkbox"/> Q-Cap IM (3cc syringe only, 25g 1.5" needle) | | | | | <input type="checkbox"/> Vivelle Dot | ____mg patches | | | |
| <input type="checkbox"/> Q-Cap SubQ (3cc syringe only, 27g 0.5" needle) | | | | | <input type="checkbox"/> Estraderm | ____mg patches | | | |
| <input type="checkbox"/> Follistim | 75 unit AQ vial | | | | <input type="checkbox"/> Estrace | ____mg tabs | | | |
| <input type="checkbox"/> Follistim | 150 unit AQ vial | | | | <input type="checkbox"/> Femtrace | ____mg | | | |
| <input type="checkbox"/> Follistim | 300 unit AQ Cartridge | | | | <input type="checkbox"/> Clomiphene Citrate | 50mg tabs | | | |
| <input type="checkbox"/> Follistim | 600 unit AQ Cartridge | | | | <input type="checkbox"/> Methylprednisolone | ____mg | | | |
| <input type="checkbox"/> Follistim | 900 unit AQ Cartridge | | | | <input type="checkbox"/> Doxycycline | 100mg tabs | | | |
| <input type="checkbox"/> Follistim Pen | | | | | <input type="checkbox"/> Baby Aspirin | 81mg tabs | | | |
| <input type="checkbox"/> Gonal-f RFF | 75 unit vial | | | | <input type="checkbox"/> Birth Control | | | | |
| <input type="checkbox"/> Gonal-f RFF | 300 unit pen | | | | <input type="checkbox"/> Prenatal Vitamin | | | | |
| <input type="checkbox"/> Gonal-f RFF | 450 unit pen | | | | <input type="checkbox"/> Folic Acid | 1mg tabs | | | |
| <input type="checkbox"/> Gonal-f RFF | 900 unit pen | | | | <input type="checkbox"/> IM (3cc22g1.5" syringe, 25g 1.5" needle) | | | | |
| <input type="checkbox"/> Gonal-f RFF | 450 unit MDV | | | | <input type="checkbox"/> SubQ (3cc22g1.5" syringe, 27g 0.5" needle) | | | | |
| <input type="checkbox"/> HCG | 10,000 unit vial | | | | <input type="checkbox"/> | | | | |
| <input type="checkbox"/> Novarel | 10,000 unit vial | | | | <input type="checkbox"/> | | | | |
| <input type="checkbox"/> Ovidrel | 250mcg syringe | | | | <input type="checkbox"/> Sharps container | | | | |
| <input type="checkbox"/> Pregnyl | 10,000 unit vial | | | | <input type="checkbox"/> Patient Edu. | | | | |

Patient is interested in patient support programs Ancillary supplies and kits provided as needed for administration

6 X **PHYSICIAN SIGNATURE REQUIRED** X
DISPENSE AS WRITTEN (Date) PRODUCT SUBSTITUTION PERMITTED (Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Fertility 030113