## **BLUEGRASS PHARMACY** | FERTILITY CARE PROGRAM ENROLLMENT FORM



FAX FORM TO: 1.866.233.8317 | PHONE: 1.855.492.0817 | EMAIL: contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION						2. PRESCRIBER INFORMATION					
Name:						Name:					
Address:						DEA #:	NPI #:	State Lic.	#:		
City, State, ZIP:						Group or Hospital:					
Primary Phone: DOB: / /					Address:						
Alternate Phone: Gender:					City, State, Zip:						
Email:						Phone: -	-	Fax: -	-		
Primary Language: Las			r of SSN:			Contact Person:		Phone: -	-		
3. INSURANCE INFO	DRMATION			-ax co <sub>l</sub>	by of <b>pre</b> .	scription and insurance	cards with this form	n, if available (fro	ont and	back)	
Primary Insurance Company Name:						Secondary Insurance Company Name:					
Primary Cardholder Name:						Secondary Cardholder Name:					
Relationship: Self Spouse/Partner Child				Depend	dent	Relationship: Self Spouse/Partner Child/Dependent					
Phone: Member ID: Grou						Phone: Member ID: Group #:					
			агоар	<i>m</i> .		T Horic.	Memberia	, ai	Бир т.		
4. DIAGNOSIS AND	CLINICAL INFORMA	IION									
Needs by Date: / / Ship to				nip to: Office Other:							
				as patient tried and failed clomiphene citrate? O Yes O No If yes, how many cycles did patient complete?							
The fall (factors)				Has patient received injection training?  Yes  No							
7 1110				Allergies: Other Medications:							
5. PRESCRIPTION IN	NFORMATION										
Medication	Dose/Strength	Direction	ons	Qty	Refills	Medication	Dose/Strength	Directions	Qty	Refills	
○ Bravelle <sup>™</sup>	75 unit vial					○ Lupron <sup>™</sup> (DAW)	2-week kit				
O Cetrotide	0.25 mg kit					○ Menopur	75 unit vial				
Clomiphene Citrate	3 mg kit 50 mg tablets					Methylprednisolone	0.50 (0.1.1.				
Crinone 8%	15 appl (26.1 gm)					Microdose Leuprolide	50 mcg/0.1 ml 10 ml vial				
Doxycylcine	100 mg tablets					○ Novarel <sup>™</sup>	10,000 unit vial		+		
○ Endometrin <sup>™</sup>	100 mg					Ovidrel™	250 mcg syringe				
○ Estrace <sup>™</sup>	mg tabs					O Pregnyl™	10,000 unit vial		+		
○ Estraderm <sup>™</sup>	mg patches					Prenatal Vitamins					
○ Femtrace <sup>™</sup>	mg					O Progesterone	mg caps				
Folic Acid						O Progesterone	mg				
○ Follistim <sup>™</sup>	unit					Suppositories	50 ( ) ; ;				
	AQ vial	AQ vial  unit				Progesterone in Oil	50 mg/ml vial				
	AQ cartridge	dge				<ul><li>Progesterone in Cottonseed Oil</li></ul>	50 mg/ml vial				
Ganirelix Acetate	250 mcg/ 0.5 ml syringe					Olive Oil	50 mg/ml vial				
○ Gonal-f™ RFF	75 unit vial					Q-cap IM (3 cc syringe	only, 25 q 1.5" needle)		+		
	450 unit MDV						Q-cap SQ (3 cc syringe only, 27 g 0.5* needle)				
O 1100	unit pen					O Repronex <sup>™</sup>	75 unit vial		+		
O HCG	10,000 unit vial					○ Vivelle Dot™	mg patches		_		
Low Dose HCG     Leuprolide Acetate	2-week kit					0					
C Leaprolide Acetate	O 2-week kit					0					
ncillary supplies and kits w	ill be provided as needed	d for admi	nistration.		Į	0					
6. PRESCRIBER SIGI	NATURE										
				/	/	x / /				/	
ISPENSE 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 or 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.