BLUEGRASS PHARMACY | FERTILITY CARE PROGRAM ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

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

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

◯ N97.9 Female infertility, unspecified
◯ Other Diagnosis:
Height (in/cm): Weight (lb/kg):

Has patient tried and failed clomiphene citrate? ◯ Yes ◯ No If yes, how many cycles did patient complete?
Has patient received injection training? ◯ Yes ◯ No
Allergies:
Other Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
◯ Bravelle™	75 unit vial			
◯ Cetrotide	◯ 0.25 mg kit ◯ 3 mg kit			
◯ Clomiphene Citrate	50 mg tablets			
◯ Crinone 8%	15 appl (26.1 gm)			
◯ Doxycylcine	100 mg tablets			
◯ Endometrin™	100 mg			
◯ Estrace™	_____ mg tabs			
◯ Estraderm™	_____ mg patches			
◯ Femtrace™	_____ mg			
◯ Folic Acid				
◯ Follistim™	◯ _____ unit AQ vial ◯ _____ unit AQ cartridge			
◯ Ganirelix Acetate	◯ 250 mcg/ 0.5 ml syringe			
◯ Gonal-f™ RFF	◯ 75 unit vial ◯ 450 unit MDV ◯ _____ unit pen			
◯ HCG	◯ 10,000 unit vial			
◯ Low Dose HCG				
◯ Leuprolide Acetate	◯ 2-week kit			

Medication	Dose/Strength	Directions	Qty	Refills
◯ Lupron™ (DAW)	◯ 2-week kit			
◯ Menopur	75 unit vial			
◯ Methylprednisolone				
◯ Microdose Leuprolide	◯ 50 mcg/0.1 ml 10 ml vial			
◯ Novarel™	◯ 10,000 unit vial			
◯ Ovidrel™	◯ 250 mcg syringe			
◯ Pregnyl™	◯ 10,000 unit vial			
◯ Prenatal Vitamins				
◯ Progesterone	_____ mg caps			
◯ Progesterone Suppositories	_____ mg			
◯ Progesterone in Oil	50 mg/ml vial			
◯ Progesterone in Cottonseed Oil	50 mg/ml vial			
◯ Progesterone in Olive Oil	50 mg/ml vial			
◯ Q-cap IM (3 cc syringe only, 25 g 1.5" needle)				
◯ Q-cap SQ (3 cc syringe only, 27 g 0.5" needle)				
◯ Repronex™	75 unit vial			
◯ Vivelle Dot™	_____ mg patches			
◯				
◯				
◯				

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE