

FAX FORM TO: 1.877.597.3070 | PHONE: 1.800.473.3516 | EMAIL: specialty@wellpartner.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION						2. PRESCRIBER INFORMATION					
Name:						Name:					
Address:				 DEA #:	NPI #:	State Lic	 c. #:				
City, State, ZIP:					Group or Hospital:						
Primary Phone: DOB: / /						Address:					
Alternate Phone: Gender:											
						City, State, Zip:					
Email:						Phone: -	-	Fax: -			
Primary Language: Last Four of			ır of SSN:			Contact Person:	Phone:				
3. INSURANCE INFO	DRMATION		F	ах сор	by of pre :	scription and insurance	cards with this form	n, if available (fi	ront and	back)	
Primary Insurance Company Name:						Secondary Insurance Company Name:					
Primary Cardholder Name:						Secondary Cardholder Name:					
Relationship: () Self () Spouse/Partner () Child				epend	dent	Relationship: () Self () Spouse/Partner () Child/Depende					
Phone: Member ID:				#·		Phone: -	- Member ID). (3	Group #:		
			Group #			. Herre.	1 1011120112		l l		
4. DIAGNOSIS AND	CLINICAL INFORMA	ATION									
Needs by Date: / / Ship to: Patient					t Office Other:						
					clomiphene citrate? O Yes O No If yes, how many cycles did patient complete?						
					eived inje	ection training? Yes No					
Height (in/cm): Weight (lb/kg): Allergie: Other M					ons:						
5. PRESCRIPTION IN	NFORMATION										
Medication	Dose/Strength	Directions		Qty	Refills	Medication	Dose/Strength	Directions	Qty	Refills	
O Bravelle™	75 unit vial					C Lupron™ (DAW)	2-week kit				
O Cetrotide	○ 0.25 mg kit○ 3 mg kit					Menopur Methylprednisolone	75 unit vial				
Clomiphene Citrate	50 mg tablets					Microdose Leuprolide	○ 50 mcg/0.1 ml				
Crinone 8%	15 appl (26.1 gm)						10 ml vial				
O Doxycylcine	100 mg tablets					O Novarel™	10,000 unit vial				
O Endometrin™	100 mg					Ovidrel™	250 mcg syringe				
○ Estrace [™]	mg tabs					O Pregnyl™	10,000 unit vial				
○ Estraderm [™]	mg patches					O Prenatal Vitamins					
O Femtrace™	mg					O Progesterone	mg caps				
○ Folic Acid○ Follistim™	unit unit					ProgesteroneSuppositories	mg				
Follistiff	AQ vial					Progesterone in Oil	50 mg/ml vial				
	Q unit AQ cartridge					Progesterone in Cottonseed Oil	50 mg/ml vial				
Ganirelix Acetate	0.5 ml syringe					Progesterone in Olive Oil	50 mg/ml vial				
O Gonal-f™ RFF	75 unit vial					Q-cap IM (3 cc syringe	onlv. 25 a 1.5" needle)				
	450 unit MDV						Q-cap SQ (3 cc syringe only, 27 g 0.5" needle)				
0.1100	unit pen					○ Repronex [™]	75 unit vial				
O HCG	10,000 unit vial					○ Vivelle Dot™	mg patches				
Low Dose HCG Leuprolide Acetate	2-week kit					0					
C Leuprolide Acetate	2-week kit					0					
Ancillary supplies and kits wi	ill be provided as neede	d for admir	nistration.			0					
6. PRESCRIBER SIGI	NATURE										
x				/	/	х				/	
DISPENSE AS WRITTEN					DATE	PRODUCT SUBSTITUTION P	PRODUCT SUBSTITUTION PERMITTED				

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