USspecialty powered by WellDyne

FERTILITY ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 **FAX:** 800-530-8589 **WEB:** www.usspecialtycare.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION

Patient:_____ Caregiver: _____

DOB:_____ ☐ Male ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Height_____ ☐ in or ☐ cm (check one) Recorded Date: _____

Address:_____ City: _____ State: _____ Zip: _____

Best Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell Email:_____

Allergies:_____ Latex Allergy: ☐ Yes ☐ No

ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT

PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

Has patient tried and failed Clomiphene Citrate? ☐ Yes ☐ No If yes, how many cycles did patient complete? _____

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS	MEDICATION	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Ganirelix Acetate	250mcg/0.5mL syringe		_____		☐ Progesterone in oil (Sesame oil)	50mg/mL vial			
☐ Cetrotide	☐ 0.25mg kit ☐ 3mg kit		_____ _____		☐ Progesterone	_____ mg caps			_____
☐ Leuprolide Acetate	2-week kit		_____		☐ Crinone 8%	15 appl (26.1GM)			_____
☐ Bravelle	75 unit vial		_____		☐ Endometrin	100mg			_____
☐ Menopur	75 unit vial		_____		Estradiol	_____ mg tabs			_____
☐ Repronex	75 unit vial		_____		Clomiphene Citrate	50mg tabs			_____
☐ Follistim	☐ 150 unit AQ vial ☐ 300 unit AQ Cartridge ☐ 600 unit AQ Cartridge ☐ 900 unit AQ Cartridge		_____ _____ _____ _____		☐ Gonal-f RFF	☐ 75 unit vial ☐ 300 unit pen ☐ 450 unit pen ☐ 900 unit pen ☐ 450 unit MDV ☐ 1050 unit MDV			_____ _____ _____ _____ _____ _____
Follistim Pen						_____ mg			
Doxycycline	100mg tabs				Birth Control				
Vivelle Dot	_____ mg patches				Folic Acid	1mg tabs			
Baby Aspirin	81mg tabs				Novarel	10,000 unit vial			
Prenatal Vitamin					Pregnyl	10,000 unit vial			
HCG	10,000 unit vial				Other				
Ovidrel	250mcg syringe								

SUPPLIES

Syringes	QTY		QTY	Syringes	QTY
3cc 18g 1.5” 3cc 22g 1.5” 3cc Insulin syringe __cc __G __inch	_____ _____ _____ _____	22g 1.5” 27G .5” 25G 1.5”	_____ _____ _____	Sharps Other	

INJECTION TRAINING: ☐ OFFICE TO COORDINATE ☐ USSC TO COORDINATE

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____

Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____

Fax #: _____ Contact Name: _____

Office Address: _____ City: _____ State: _____ Zip: _____

The terms and conditions posted at www.usspecialtycare.com have been read by the person signing this form and are incorporated into this document by reference.
The data privacy terms posted at www.usspecialtycare.com have been read by the person signing this form and are incorporated into this document by reference.

☐ I understand that USSC may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.

Prescriber’s Name: _____ Prescriber’s Signature: _____ Date: _____

☐ Use substitution ☐ Dispense as Written