

Ship Meds to:  Patient's Home  Prescriber's Office

**Prescriber Information**

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:	
Office Contact:			Practice Name / Collaborating Physician:		
Address:			City:		
State:	Zip:	Phone:			Fax:

**Patient Information | PLEASE SEND COPY OF INSURANCE CARD**

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:		City:	State:	Zip:	Allergies:	
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

**Insurance Information**

Primary Insurance:	Policy ID:	Group #:	
Policyholder Name:	Policyholder DOB:	BIN:	PCN:

**Clinical Information | PLEASE SEND COPY OF MEDICAL AND PRESCRIPTION INSURANCE CARDS, PROGRESS NOTES AND LAB REPORTS, SUPPORTING DIAGNOSIS, CO-MORBIDITIES AND LAB VALUES**

ICD-10/Diagnosis Code:	Cycle type: <input type="radio"/> IUI <input type="radio"/> IVF <input type="radio"/> FET <input type="radio"/> OTHER: _____	Cycle #: _____	Approximate Start Date: / /
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**Prescription Information**

Medication	Dose/Strength	Sig	Quantity/ Days Supply	Refills
<input type="radio"/> <b>CETROTIDE®</b> (cetrotirelix acetate)	<input type="radio"/> 0.25mg vial			
<input type="radio"/> <b>FOLLISTIM AQ®</b> (follitropin beta)	<input type="radio"/> 300IU cartridge <input type="radio"/> 600IU cartridge <input type="radio"/> 900IU cartridge			
<input type="radio"/> <b>GANIRELIX</b>	<input type="radio"/> 250mcg/0.5mL injection			
<input type="radio"/> <b>GONAL-F® RFF</b> (follitropin alfa)	<input type="radio"/> 300 IU Redi-ject pen <input type="radio"/> 450 IU Redi-ject pen <input type="radio"/> 900 IU Redi-ject pen <input type="radio"/> 75 IU vial			
<input type="radio"/> <b>GONAL-F® MULTI-DOSE</b> (follitropin alfa)	<input type="radio"/> 450 IU vial <input type="radio"/> 1050 IU vial			
<input type="radio"/> <b>HCG</b>	<input type="radio"/> 10,000 IU vial			
<input type="radio"/> <b>LEUPROLIDE ACETATE</b>	<input type="radio"/> 2 week kit (1mg/0.2mL)			
<input type="radio"/> <b>MENOPUR®</b> (menotropins for injection)	<input type="radio"/> 75 IU vial			
<input type="radio"/> <b>NOVAREL®</b> (chorionic gonadotropin)	<input type="radio"/> 5,000 IU vial <input type="radio"/> 10,000 IU vial			
<input type="radio"/> <b>OVIDREL®</b> (choriogonadotropin alfa)	<input type="radio"/> 250mcg/0.5ml PFS	<input type="radio"/> Inject the contents of 1 syringe SQ when directed by prescriber		
<input type="radio"/> <b>PREGNYL®</b> (chorionic gonadotropin)	<input type="radio"/> 10,000 IU vial			
<input type="radio"/> <b>OTHER:</b>				

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber Signature:	Date
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Prescriber Signature:	Date
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Substitution Permitted

Dispense as Written

If brand is required, please write "DAW" in the box to the right.

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