

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female SSN: \_\_\_\_\_ Wt (kg/lbs): \_\_\_\_\_ Ht (cm/in): \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_  
 Caregiver Name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Insurance Plan: \_\_\_\_\_ Plan ID: \_\_\_\_\_ BIN #: \_\_\_\_\_ PCN #: \_\_\_\_\_ GRP #: \_\_\_\_\_

Please fax a copy of the front and back of the insurance card(s).

**Prescriber + Shipping Information**

Prescriber Name: \_\_\_\_\_ DEA: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alternate: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_  
 If shipping to prescriber:  First Fill  Always  Never

**Clinical Information (Please fax all pertinent clinical and lab information)**

Diagnosis (ICD-10 code + description):  \_\_\_\_\_  \_\_\_\_\_  \_\_\_\_\_  
 Allergies:  NKDA  Other: \_\_\_\_\_

**Prescription (Medication, Dose, Strength, Directions, Quantity, Refills)**
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<input type="checkbox"/> Ganirelix Acetate	250mcg/0.5ml syringe	<input type="checkbox"/> Low Dose HCG	
<input type="checkbox"/> Cetrotide	<input type="checkbox"/> 0.25mg kit <input type="checkbox"/> 3mg kit	<input type="checkbox"/> Insulin Syringe	0.5cc
<input type="checkbox"/> Leuprolide Acetate	2-week kit	<input type="checkbox"/> Progesterone in oil	50mg/ml vial
<input type="checkbox"/> Lupron (DAW)	2-week kit	<input type="checkbox"/> Progesterone in Cottonseed oil	50mg/ml vial
<input type="checkbox"/> Insulin Syringe	0.5cc	<input type="checkbox"/> Progesterone in Olive oil	50mg/ml vial
<input type="checkbox"/> Microdose Leuprolide	50mcg/0.1ml 10ml vial	<input type="checkbox"/> 3cc 18g 1.5" Syringe, 22g 1.5" Needle	
<input type="checkbox"/> Insulin Syringe	0.5cc	<input type="checkbox"/> Progesterone	_____ mg caps
<input type="checkbox"/> Bravelle	75 unit vial	<input type="checkbox"/> Progesterone suppositories	_____ mg
<input type="checkbox"/> Menopur	75 unit vial	<input type="checkbox"/> Crinone 8%	15 appl (26.1GM)
<input type="checkbox"/> Repronex	75 unit vial	<input type="checkbox"/> Endometrin	100mg
<input type="checkbox"/> Q-Cap IM (3cc syringe only, 25g 1.5" needle)		<input type="checkbox"/> Vivelle Dot	_____ mg patches
<input type="checkbox"/> Q-Cap SubQ (3cc syringe only, 27g 0.5" needle)		<input type="checkbox"/> Estraderm	_____ mg patches
<input type="checkbox"/> Follistim	75 unit AQ vial	<input type="checkbox"/> Estrace	_____ mg tablets
<input type="checkbox"/> Follistim	150 unit AQ vial	<input type="checkbox"/> Femtrace	_____ mg
<input type="checkbox"/> Follistim	300 unit AQ Cartridge	<input type="checkbox"/> Clomiphene Citrate	50mg tablets
<input type="checkbox"/> Follistim	600 unit AQ Cartridge	<input type="checkbox"/> Methylprednisolone	_____ mg
<input type="checkbox"/> Follistim	900 unit AQ Cartridge	<input type="checkbox"/> Doxycycline	100mg tablets
<input type="checkbox"/> Follistim Pen		<input type="checkbox"/> Baby Aspirin	81mg tablets
<input type="checkbox"/> Gonal-f RFF	75 unit vial	<input type="checkbox"/> Birth Control	
<input type="checkbox"/> Gonal-f RFF Redi-ject	300 unit pen	<input type="checkbox"/> Prenatal Vitamin	
<input type="checkbox"/> Gonal-f RFF Redi-ject	450 unit pen	<input type="checkbox"/> Folic Acid	1mg tablets
<input type="checkbox"/> Gonal-f RFF Redi-ject	900 unit pen	<input type="checkbox"/> IM (3cc22g1.5" syringe, 25g 1.5" needle)	
<input type="checkbox"/> Gonal-f RFF	450 unit MDV	<input type="checkbox"/> SubQ (3cc22g1.5" syringe, 27g 0.5" needle)	
<input type="checkbox"/> HCG	10,000 unit vial	<input type="checkbox"/> Sharps container	
<input type="checkbox"/> Novarel	10,000 unit vial	<input type="checkbox"/> Patient Edu.	
<input type="checkbox"/> Ovidrel	250mcg syringe	<input type="checkbox"/>	
<input type="checkbox"/> Pregnyl	10,000 unit vial	<input type="checkbox"/>	

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize AmeriPharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to AmeriPharma.

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