# Specialty Pharmacy Fertility Care Program Enrollment Form

ENCOMPASS Rx
Leaders In Chronic Disease Management

**Fax Referral To:** 844-364-9364 **Phone:** 404-528-1728
**Address:** 2700 Northeast Expressway NE Suite B-800, Atlanta, GA 30345

**Six Simple Steps to Submitting a Referral**

## 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*
Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: ☐ Male ☐ Female
Email: _____ Last Four of SSN: _____ Primary Language: _____

## 2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
Phone: _____ Fax _____ Contact Person: _____ Contact's Phone: _____

## 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

## 4 CLINICAL INFORMATION

Needs by Date: _____ Ship to: ☐ Patient ☐ Office ☐ Other: _____
Allergies: _____ Weight: _____lb/kg Height: _____in/cm

## 5 PRESCRIPTION INFORMATION

| MEDICATION & STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|
| ☐ Cetrotide® 0.25 mg Syringe | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Ganirelix® 250 mcg/0.5mL | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Leuprolide 2 Week Kit | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Leuprolide Micro Dose _____ mcg / _____ mL | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Follistim® AQ 300 IU Cartridge | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Follistim AQ 600 IU Cartridge | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Follistim AQ 900 IU Cartridge | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Follistim Pen® | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Gonal-F® 450 IU MDV | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Gonal-F 1050 IU MDV | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Gonal-F RFF 75 IU Vial | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Gonal-F RFF Rediject™ 300 IU Pen | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Gonal-F RFF Rediject 450 IU Pen | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Gonal-F RFF Rediject 900 IU Pen | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Menopur® 75 IU Vial | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ HCG Low Dose _____ Units / _____ mL Vial | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ HCG 10,000 Unit Vial | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Novarel® 5,000 Unit Vial | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Pregnyl® 10,000 Unit Vial | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Ovidrel® 250 mcg / 0.5 mL | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Crinone® 8% Gel | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Endometrin® 100 mg | ☐ Other: _____ | Quantity: ____ Refills: ____ |
| ☐ Prometrium® _____ mg | ☐ Other: _____ | Quantity: ____ Refills: ____ |

Patient is interested in patient support programs

**STAMP SIGNATURE NOT ALLOWED**

Ancillary supplies and kits provided as needed for administration

## 6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date)
X_____

DISPENSE AS WRITTEN (Date)
X_____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

# Specialty Pharmacy Fertility Care Program Enrollment Form

**Please complete Patient and Prescriber information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION & STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|
| ☐ Progesterone Compounded Capsules _____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Progesterone Suppositories ____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Progesterone / Sesame Oil 50 mg / mL Vial | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Progesterone( ____) 50 mg / mL Vial | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Delestrogen® _____ mg / mL | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Syringe 1 mL only | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Syringe 3 mL only | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Syringe 3 mL 18g 1.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Syringe 3 mL 22g 1.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Needle 18 g 1.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Needle 22 g 1.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Needle 25 g 1.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Needle 25 g 5/8” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Needle 27 g 0.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Needle 30 g 0.5” | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Insulin Syringe ____ mL | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Aspirin 81 mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Azithromycin _____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Cabergoline 0.5 mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Citranatal®_____ | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Clomiphene 50 mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Dexamethasone _____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Doxycycline 100 mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Estradiol ____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Folic Acid 1 mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Letrozole 2.5 mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Methylprednisolone _____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Prednisone _____ mg | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Prenatal Plus | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Z-Pak® 250 mg #6 Tablets | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Climara® 0.1 mg Patch | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Minivelle® 0.1 mg Patch | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Vivelle DOT® 0.1 mg Patch | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Heparin _____ units / mL Vial | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Lovenox® _____ mg Syringes | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Other: _____ | ☐ Other: _____ | Quantity: _____ Refills: _____ |
| ☐ Other: _____ | ☐ Other: _____ | Quantity: _____ Refills: _____ |

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X_____

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