Infertility Enrollment Form

InfuCare Rx

Phone: (844) 773-6779
Fax: (844) 533-1131
Website: www.InfuCareRx.com

PATIENT INFORMATION			PRESCRIBER INFORMATION		
Name:			Prescribing Practitioner:		NPI:
Address:			Address:		
City:	State/Zip:		City:		State/Zip:
Telephone:	DOB:	M ☐ F ☐	Office:		
Language Preference:	Wt:	Ht:	Contact:	Phone:	Fax:

PRIMARY INSURANCE INFORMATION			
Member Name:	M ☐ F ☐	DOB:	
Address:	City:		
State:	Zip:	Telephone:	Alt. Telephone:
Member ID:	Rx Group #:	BIN#:	
PCN#:	Customer Service #:	Please attach a copy of the front and back of the patient's insurance card, if available.*****	

PLEASE FAX COPY OF: ☐ PRESCRIPTION FRONT & BACK ☐ CLINICAL NOTES ☐ MEDICAL CARD FRONT & BACK

PRESCRIPTION

New ☐ Refill ☐ | Ship by: | Ship to: ☐ Patient's Home ☐ Doctor's Office ☐ Other:_____

Drug	Strength	Directions	Quantity	Refills
Bravelle®	☐ 75IU			
Follistim AQ Vial®	☐ 75IU ☐ 150IU			
Follistim AQ Cartridge®	☐ 75IU ☐ 150IU ☐ 75IU ☐ 150IU			
Gonal-F®	☐ 450IU			
Glonal-F REF Vial®	☐ 75IU			
Glonal-F REF Pen®	☐ 300IU ☐ 450IU ☐ 900IU			
HCG®	☐ 10,000 units			
Lupron®	☐ 5mg/mL 14 day			
Cetrotide®	☐ 0.25mg ☐ 3mg			
Ganirelix®	☐ 250mcg syringe			

DIAGNOSIS AND CLINICAL INFORMATION

***PLEASE FAX COPY OF PRESCRIPTION/MEDICAL CARD, FRONT AND BACK AS WELL AS ANY CLINICAL NOTES REGARDING THERAPY

Diagnosis Description and ICD10:

Additional Clinical Information:

Expected Date of next dose: ____/____/_____

Prior Medication Failed: _____

Length of Treatment:_____

Reason for Discontinuation: _____

Allergies:

PRESCRIBING PRACTITIONER SIGNATURE

To Prescribing Practitioner: By signing this form and utilizing our services, you are also authorizing FOSRX/FAST to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies and co-pay foundations.

Prescribing Practitioner Signature: | **Date:**