FACTOR ONE SOURCE FAST PHARMACY

FAX 1-844-504-3278
PHONE 1-877-327-8881
www.FASTACCESSRX.com

INFERTILITY FORM

PATIENT INFORMATION:

Patient Name:_____
Date of Birth:_____Male: ☐ Female: ☐
Address:_____
City/State/Zip:_____
Tel:_____Alt Tel:_____
SS#:_____Wt:_____Ht:_____

NKDA: ☐ Allergy:_____

INSURANCE INFORMATION:

Primary Pharmacy Insurance_____
Member Name:_____
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.**

DIAGNOSIS AND CLINICAL INFORMATION:

Diagnosis and ICD10:_____
Expected Date of next dose:_____Deliver to ☐ Patient Home ☐ MD Office

PRESCRIBER INFORMATION:

Prescriber Name:_____Specialty:_____Date:_____
Address:_____City/State/Zip:_____
Contact Name:_____Phone #:_____Fax #:_____
NPI#:_____DEA #:_____UPIN #:_____

By signing this form and using our services, you are authorizing F.A.S.T. to serve as your prior authorization designated agent in dealing with prescription and medical insurance companies.
Prescriber Signature Below: (*Physician attests this is his/her legal signature.* **NO STAMPS**)

_____ _____
Substitution Allowed *Dispense as Written*

PRESCRIPTION:

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Bravelle	☐ 75IU			
☐ Follistim AQ Vial	☐ 75IU ☐ 150IU			
☐ Follistim AQ Cartridge	☐ 150IU ☐ 300IU ☐ 600IU ☐ 900 IU			
☐ Gonal-F	☐ 450IU			
☐ Gonal-F RFF Vial	☐ 75IU			
☐ Gonal-F RFF Pen	☐ 300IU ☐ 450IU ☐ 900IU			
☐ HCG	☐ 10,000 units			
☐ Lupron	☐ 5mg/ml 14 day			
☐ Cetrotide	☐ 0.25mg ☐ 3mg			
☐ Ganirelix	☐ 250mcg syringe			
☐ Other				