Infertility Enrollment Form

FACTOR ONE SOURCE
FAST PHARMACY
Powered By: InfuCare Rx

Phone: 1-833-367-3278
Fax: 1-844-504-3278
Website: www.FOSRXFAST.com

Louisiana Office
2400 Veterans Memorial Blvd., Suite 480
Kenner, LA 70062

PATIENT INFORMATION / PRESCRIBER INFORMATION

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.*****	

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:**