

FERTILITY CENTER: _____

Address: _____

City, State, Zip code: _____

Phone: _____ Fax: _____

Date: _____ From: _____ RN, IVF

First Name: _____ Last Name: _____ DOB: _____

Address: _____ City, State, Zip code: _____

Home #: _____ Work #: _____ Cell #: _____

Bravelle 75IU Vial
Sig: _____ Qty _____ Refills

Follistim™ AQ 75IU Vials
Sig: _____ Qty _____ Refills

Follistim™ AQ 150IU Vials
Sig: _____ Qty _____ Refills

Follistim™ AQ Cartridges 300IU
Sig: _____ Qty _____ Refills

Follistim™ AQ Cartridges 600IU
Sig: _____ Qty _____ Refills

Follistim™ AQ Cartridges 900IU
Sig: _____ Qty _____ Refills

Gonal-F® RFF 75IU Vial
Sig: _____ Qty _____ Refills

Gonal-F® 450IU Multi-dose Kit
Sig: _____ Qty _____ Refills

Gonal-F® RFF Pen 300IU
Sig: _____ Qty _____ Refills

Gonal-F® RFF Pen 450IU
Sig: _____ Qty _____ Refills

Gonal-F® RFF Pen 900IU
Sig: _____ Qty _____ Refills

Luveris® 75IU Vial
Sig: _____ Qty _____ Refills

Menopur® 75IU Vial
Sig: _____ Qty _____ Refills

Repronex® 75IU Vial
Sig: _____ Qty _____ Refills

HCG 10,000IU Vial
Sig: _____ Qty _____ Refills

Ovidrel Prefilled Syringes 250mcg
Sig: _____ Qty _____ Refills

Sharps Package- No Charge
(Sharps disposal unite, alcohol wipes, gauze, disposal instructions, etc.)

3cc 22g 1½" Needle & Syringe # _____ Refills

18g 1½" Needles # _____ Refills

25g 1½" Needles # _____ Refills

25g 5/8" Needle # _____ Refills

½ cc Syringe # _____ Refills

Follistim Pen # _____ Refills

Other _____ # _____ Refills

Syringes and needles will NOT be dispensed unless indicated

Antagon/Ganirelix Prefilled Syringes 250UG/0.5ml
Sig: _____ Qty _____ Refills

Cetrotide 0.25mg 3mg
Sig: _____ Qty _____ Refills

Lupron 2-Week Kit
 Extra Lupron Syringes to be refilled only after request by patient
Sig: _____ Qty _____ Refills

Lupron Microdose _____mcg/0.1ml 5ml Vial
_____mcg/0.2ml 5ml Vial
Sig: _____ Qty _____ Refills

Progesterone in Sesame Oil 50mg/ml 10ml Vial
Sig: _____ Qty _____ Refills

Progesterone Vaginal Suppositories
 50mg 100mg 200mg
Sig: _____ Qty _____ Refills

Prometrium Capsules 200mg
Sig: _____ Qty _____ Refills

Clomiphene Citrate 50mg
Sig: _____ Qty _____ Refills

Doxycycline 100mg
Sig: _____ Qty _____ Refills

Estrace® 0.5mg 1mg 2mg
Sig: _____ Qty _____ Refills

Prednisone _____mg
Sig: _____ Qty _____ Refills

Other _____
Sig: _____ Qty _____ Refills

Other _____
Sig: _____ Qty _____ Refills

Other _____
Sig: _____ Qty _____ Refills

Anticipated Start Date: _____

Physician's Signature: _____

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTIONS" in this space.

_____, M.D.

DEA#: _____

This fax is for informational purposes only and does not constitute as a prescription order.