@pfsprx #pfsprx

☐ Phone Order
Ship to Patient: ☐ Home ☐ Work
Ship to: ☐ Physician Office
☐ Nurse / Training
☐ PFSP Pharmacy

VERBAL ORDER FORM
WOMEN'S HEALTH

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NPI# 1669881777 NABP# 3148839
info@pfsprx.com PFSPrx.com

Today's Date ____________
Date Needed ____________

Patient Name________________________ Date of Birth____________ ☐ Male ☐ Female
Address________________________ Apt #_____ City____________ State_____ Zip________
Telephone____________ Cell____________ SSN____________ Email____________
Allergies________________________ Comorbidities________________________

Primary Insurance________________________ ID#____________ Group #____________
Insured's Name________________________ Employer________________________
City____________ State________ Phone____________

ICD-10 Diagnosis Code: ☐ ____________ Weight ________ BSA ________m^2
Patient currently on therapy? ☐ Yes ☐ No Date of next blood work ____________
Current medications (including OTC) with dosage and direction (or fax) ____________

PRESCRIPTION — PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

☐ **CRINONE** ☐ 4% gel/6 single use applicators ☐ 8% gel/15 single use applicators
Amenorrhea:
☐ Insert 45mg (4%) gel intravaginally every other day for a total of 6 doses. QTY: ____ Refill: ____
☐ Insert 90mg (8%) gel intravaginally every other day for a total of 6 doses. QTY: ____ Refill: ____
Assisted reproductive technology/luteal phase support:
☐ Insert 90mg (8%) gel intravaginally once daily. QTY: ____ Refill: ____
☐ Insert 90mg (8%) gel intravaginally twice daily. QTY: ____ Refill: ____
Spontaneous preterm birth:
☐ Insert 90mg (8%) gel intravaginally once daily. QTY: ____ Refill: ____

☐ **ENDOMETRIN** vaginal suppository, box of 21 inserts
Assisted reproductive technology/luteal phase support:
☐ Insert 100mg intravaginally 2 times daily. QTY: ____ Refill: ____
☐ Insert 100mg intravaginally 3 times daily. QTY: ____ Refill: ____

☐ **FOLLISTIM AQ** Pre-filled cartridge: ☐ 300 IU ☐ 600 IU ☐ 900 IU
Ovulation induction, anovulatory patients:
☐ Initiate therapy at 50 units SQ per day for 7 days. QTY: ____ Refill: ____
☐ Inject _____ units SQ per day. QTY: ____ Refill: ____
Controlled ovarian stimulation, ovulatory patients:
☐ Initiate therapy at 200 units SQ per day for 7 days. QTY: ____ Refill: ____
☐ Inject _____ units SQ per day. QTY: ____ Refill: ____

☐ **GONAL-F** Pen: ☐ 300IU/0.5ml ☐ 450IU/0.75ml ☐ 900IU/1.5ml
Ovulation induction, anovulatory patients:
☐ Inject 75 units SQ daily. QTY: ____ Refill: ____
☐ Inject _____ units SQ daily. QTY: ____ Refill: ____
Multifollicular development during assisted reproductive technology:
☐ Inject 150 units SQ daily. QTY: ____ Refill: ____
☐ Inject _____ units SQ daily. QTY: ____ Refill: ____

☐ **LUPRON DEPOT** ☐ 3.75mg Kit ☐ LD- 3 Month 11.25mg Kit
Endometriosis - initial and recurrence:
☐ Inject 3.75 mg IM every month. QTY: ____ Refill: ____
☐ Inject 11.25 mg IM 3 every months. QTY: ____ Refill: ____
Uterine leiomyomata, fibroids:
☐ Inject 3.75 mg IM every month. QTY: ____ Refill: ____
☐ Inject 11.25 mg IM as a single injection. QTY: ____ Refill: ____

☐ **MENOPUR** 5 vials of 75 IU vial/box
Assisted reproductive technology:
☐ Inject 225 mg SQ once daily beginning on cycle day 2 or 3. QTY: ____ Refill: ____
☐ Inject _____ mg SQ once daily. QTY: ____ Refill: ____

☐ **NOVAREL** 5,000 IU vial *Ovulation Induction:*
☐ Inject _____ units IM 1 day following last dose of menotropins. QTY: ____ Refill: ____

☐ **OVIDREL** 250mcg PFS ***Assisted reproductive technology and ovulation induction:***
☐ Inject 250 mcg SQ given 1 day following the last dose of follicle stimulating agent. QTY: ____ Refill: ____

☐ **PREGNYL** 10ml Multi-dose vial ***Ovulation Induction:***
☐ Inject _____ units IM 1 day following last dose of menotropins. QTY: ____ Refill: ____

☐ **CETROTIDE** 0.25mg vial with PFS ***Controlled ovarian stimulation:***
☐ Inject 0.25 mg SQ once daily. QTY: ____ Refill: ____

☐ **GANIRELIX/FYREMADEL** 250mcg PFS ***Adjunct to controlled ovarian hyperstimulation:***
☐ Inject 250 mcg SQ once daily. QTY: ____ Refill: ____

☐ **SYNAREL** 2mg/mL nasal spray bottle with 60 metered sprays
☐ **Endometriosis:** One spray (200mcg) into 1 nostril each morning & one spray (200mcg) into the other nostril each evening starting between days 2 and 4 of menstrual cycle. QTY: ____ Refill: ____

☐ **CLOMIPHENE** 50mg tablet : ☐ 10-count ☐ 30-count
Ovulation induction and repeat course:
☐ Take 50 mg by mouth once daily for 5 days. QTY: ____ Refill: ____
☐ Take 100 mg by mouth once daily for 5 days. QTY: ____ Refill: ____

☐ **FORTEO** 600mcg/2.4mL SIG: Inject 20mcg SQ daily as directed
QTY: ☐ 1 Pen (4 week supply) ☐ 3 Pens (12 week supply) Refill: ______

☐ **PROLIA** 60mg PFS SIG: Inject 60mg SQ every 6 months QTY: ____ Refill: ____

☐ **RECLAST** 5mg/100mL Vial SIG: 5mg IV once yearly QTY: ____ Refill: ____

☐ **EVENITY** 105mg/1.17mL PFS (2-count) ☐ 2 PFS (1 month) ☐ 6 PFS (3 months)
SIG: Inject 210mg (2-105mg PFS) under the skin once monthly for 12 months Refill: ____

☐ **RHOGAM** 1,500 IU (300 mcg) PFS
☐ **RhD suppression for antepartum prophylaxis:** Inject 300mcg IM at 26 to 28 weeks gestation. QTY: ____ Refill: ____
☐ **RhD suppression for postpartum prophylaxis:** Inject 300mcg IM. QTY: ____ Refill: ____
☐ **Abdominal trauma:** Inject 300mcg IM within 72 hours following abdominal trauma. QTY: ____ Refill: ____
☐ **Amniocentesis:** Inject 300mcg IM within 72 hours of a procedure. QTY: ____ Refill: ____
☐ **Ectopic pregnancy:** Inject 300mcg IM within 72 hours of complications. QTY: ____ Refill: ____
☐ **Termination of pregnancy (spontaneous or induced):** Inject 300mcg IM within 72 hours following spontaneous or induced termination occurring. QTY: ____ Refill: ____

☐ **OTHER:** ____________ SIG: ____________ QTY: ____ Refill: ____

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS PRESCRIBER WRITES "D A W" IN THIS BOX ☐

Prescriber's Name / Practice ________________________ Office Contact____________
Address________________________ Suite#______ City____________ State______ Zip________
Tel____________ Fax____________ Email____________
License#____________ NPI#____________ UPIN#____________ DEA#____________
Prescriber's Signature (signature required. NO STAMPS)________________________ **Date**____________

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