



**FREEDOM FERTILITY PHARMACY
MEDICATION ORDER**

Phone: 800-660-4283
Fax: 888-660-4283

Center: _____

Address: _____

Phone: _____ Fax: _____

Prescribing Physician: _____

NPI: _____

DEA: _____

PATIENT INFORMATION Anticipated Start Date: _____

First Name: _____ Last Name: _____

DOB: ____/____/____ Allergies: _____ Medical Conditions: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

<input type="checkbox"/> CRYO/AH	<input type="checkbox"/> CRYO CYCLE	<input type="checkbox"/> IVF	<input type="checkbox"/> ICSI/AH	<input type="checkbox"/> RECIPIENT (Egg Donation)	<input type="checkbox"/> EGG DONOR	<input type="checkbox"/> IUI (Partner)	<input type="checkbox"/> IUI (Donor)
<input type="checkbox"/> Cetrotide® 0.25mg _____ Kits to be dispensed Sig: _____ Refills _____				<input type="checkbox"/> Crinone® 8% Gel Applicators _____ Apps to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Ganirelix Acetate 250mcg/0.5ml _____ PFS to be dispensed Sig: _____ Refills _____				<input type="checkbox"/> Endometrin® 100mg _____ Inserts to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Leuprolide Acetate 2 Week Kit _____ Kits to be dispensed <input type="checkbox"/> <i>Extra Leuprolide Syringes to be refilled only after request by patient</i> Sig: _____ Refills _____				<input type="checkbox"/> Progesterone in Sesame Oil 50mg/ml _____ 10ml vials to be dispensed Sig: _____ Refills _____ <input type="checkbox"/> 18g 1½" 3cc syringe & needle _____ # _____ Refills <input type="checkbox"/> 22g 1½" needle _____ # _____ Refills			
<input type="checkbox"/> Microdose Leuprolide Acetate _____ <i>Compounded Preparation</i> <input type="checkbox"/> 40mcg/0.1ml <input type="checkbox"/> 40mcg/0.2ml _____ 6ml vials to be dispensed <input type="checkbox"/> 50mcg/0.1ml <input type="checkbox"/> 50mcg/0.2ml _____ # _____ <input type="checkbox"/> <i>Leuprolide Syringes</i> _____ Refills _____ Sig: _____				<input type="checkbox"/> Progesterone Vaginal Suppositories _____ <i>Compounded Preparation</i> <input type="checkbox"/> 50mg <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg _____ Supp. to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Lupron Depot® 3.75mg _____ Kits to be dispensed Sig: _____ Refills _____				<input type="checkbox"/> Progesterone Vaginal Caps 200mg _____ <i>Compounded Preparation</i> Sig: _____ Caps to be dispensed Refills _____			
<input type="checkbox"/> Gonal-f® RFF Redi-ject™ 300IU _____ Each _____ Refills <input type="checkbox"/> Gonal-f® RFF Redi-ject™ 450IU _____ Each _____ Refills <input type="checkbox"/> Gonal-f® RFF Redi-ject™ 900IU _____ Each _____ Refills Sig: _____				<input type="checkbox"/> Prometrium® <input type="checkbox"/> 100mg <input type="checkbox"/> 200mg _____ Caps to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Gonal-f® Multi-Dose 450IU _____ Vials to be dispensed <input type="checkbox"/> Gonal-f® Multi-Dose 1050IU _____ Vials to be dispensed Sig: _____ Refills _____				<input type="checkbox"/> Estrace® <input type="checkbox"/> 1mg <input type="checkbox"/> 2mg _____ Tabs to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Follistim AQ 300IU Cartridge _____ Each _____ Refills <input type="checkbox"/> Follistim AQ 600IU Cartridge _____ Each _____ Refills <input type="checkbox"/> Follistim AQ 900IU Cartridge _____ Each _____ Refills Sig: _____ <input checked="" type="checkbox"/> Follistim Pen _____ Pens _____ Refills				<input type="checkbox"/> Vivelle Dot <input type="checkbox"/> 0.05mg <input type="checkbox"/> 0.1mg _____ Dots to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Menopur® 75IU Vial _____ Vials to be dispensed Sig: _____ Refills _____ <input type="checkbox"/> 27g ½" needle _____ # _____ Refills <input type="checkbox"/> 3cc syringe _____ # _____ Refills				<input type="checkbox"/> Clomiphene Citrate 50mg _____ Tabs to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Leuprolide Acetate Trigger Kit MG to be injected: _____ mg _____ Kits to be dispensed Sig: _____ Inject _____ ml SQ for trigger shot _____ Refills				<input type="checkbox"/> Doxycycline 100mg _____ Caps to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Other _____ To be dispensed Sig: _____ Refills _____				<input type="checkbox"/> Medrol® <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg <input type="checkbox"/> 16mg _____ Tabs to be dispensed Sig: _____ Refills _____			
<input type="checkbox"/> Other _____ To be dispensed Sig: _____ Refills _____				<input type="checkbox"/> Z-pak _____ To be dispensed Sig: _____ Refills _____			
				<input type="checkbox"/> Other _____ To be dispensed Sig: _____ Refills _____			
				<input type="checkbox"/> Sharps Package – Sharps disposal unit, alcohol wipes, gauze, disposal instructions, etc. <input type="checkbox"/> 22g 1½" 3cc syringe and needle _____ # _____ Refills <input type="checkbox"/> 18g 1½" 3cc syringe and needle _____ # _____ Refills <input type="checkbox"/> 25g 5/8" needle _____ # _____ Refills <input type="checkbox"/> 20g 1½" filter needle _____ # _____ Refills			

Submitted by: _____ RN, IVF Today's Date: _____

Physician's Signature: _____ M.D. *PHYSICIAN MUST SIGN MEDICATION ORDER!

Date: _____ Dispense as written: _____ Date: _____ Substitution allowed: _____