SAVE IVF
YOUR #1 TRUSTED IVF MEDICATIONS PROVIDER

Phone: 1 (800) 439-6086 | Fax: 1 (877) 325-2283

Center: _____

Address: _____

_____

Phone: _____ **Fax:** _____

PATIENT INFORMATION Antipicated Start Date: _____

First Name: _____ Last Name: _____

DOB: / / Allergies: _____ Medical Conditions: _____

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

Home: ( ) - Work: ( ) - Mobile: ( ) -

☐ **Fostimon®** 75IU Vial Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Fostimon®** 150IU Vial Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Gonal-f® RFF** Redi-ject™ 300IU Sig: _____	_____ _____	Each Refills
☐ **Gonal-f® RFF** Redi-ject™ 450IU Sig: _____	_____ _____	Each Refills
☐ **Gonal-f® RFF** Redi-ject™ 900IU Sig: _____	_____ _____	Each Refills
☐ **Gonal-f® Multi-Dose** 450IU Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Gonal-f® Multi-Dose** 1050IU Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Menopur®** 75IU Vial Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Merional®** 75IU Vial Sig:	_____ _____	Vials to be dispensed Refills
☐ **Merional®** 150IU Vial Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Menogon®** 75IU Vial Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Estrace®** ☐ 1mg ☐ 2mg Sig: _____	_____ _____	Tabs to be dispensed Refills
☐ **Doxycycline®** 100mg Sig: _____	_____ _____	Caps to be dispensed Refills

☐ **Leuprolide Acetate** 2 Wk Kit Sig: _____	_____ _____	Kits to be dispensed Refills
☐ **Lurpon Depot®** 3.75mg Sig: _____	_____ _____	Kits to be dispensed Refills
☐ **Lurpon Depot®** 11.75mg Sig: _____	_____ _____	Kits to be dispensed Refills
☐ **Cetrotide®** 0.25mg Sig: _____	_____ _____	Kits to be dispensed Refills
☐ **Ovidrel®** 250mcg/0.5ml Sig: _____	_____ _____	Kits to be dispensed Refills
☐ **Progestan®** 100mg/30caps Sig: _____	_____ _____	Caps to be dispensed Refills
☐ **Progestan®** 200mg/30caps Sig: _____	_____ _____	Caps to be dispensed Refills
☐ **Crinone® 8% Gel** 15 Apps Sig: _____	_____ _____	Apps to be dispensed Refills
☐ **Choriomon®** 5000IU Sig: _____	_____ _____	Vials to be dispensed Refills
☐ **Omnitrope®** 5mg/1.5ml Sig: _____	_____ _____	Kits to be dispensed Refills
☐ **Z-pak** 500mg Sig: _____	_____ _____	To be dispensed Refills
☐ **Other** Sig: _____	_____ _____	To be dispensed Refills
☐ **Other** Sig: _____	_____ _____	To be dispensed Refills

Submitted By: _____ RN, IVF **Today's Date:** _____

Prescriber's Signature _____ *PRESCRIBER MUST SIGN MEDICATION ORDER!