Schraft's Fax Form
Fax to 800-572-1014

Customer Service: 800-876-4545

MEDICA®

Patient Information Please type or print clearly.	Name		
	Address		
	City	State	ZIP Code
	DOB		
	Home Phone w/area code	Work Phone w/area code	
Insurance Information ☐ Major Medical ☐ Rx Benefit Please attach a copy of card(s) if possible.	Primary Insurer		
	Cardholder		
	DOB		
	Cardholder ID #	Group #	
	RxCard ID #	RxBin #	RxGroup #
	Phone w/area code	Fax w/area code	
Medical Assessment	Diagnosis		
	Allergies		
Physician Certification ☐ Please acknowledge receipt of this fax.	I certify that the prescribed therapy is medically necessary and that the information on this form is accurate to the best of my knowledge.		
	MD Signature (required)	Date	
	Print MD Name		
	Form Faxed By	UPIN	
	Address	DEA #	
	City	State	ZIP Code
	Phone w/area code	Fax w/area code	

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Redisclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

IMPORTANT WARNING: This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately.

Drug Names are the property of their respective owners.

©2006 Walgreens Specialty Pharmacy SP4453-0606

Schraft's Fax Form
Fax to 800-572-1014

Customer Service: 800-876-4545

MEDICA®

Prescription

To be valid, prescription must be faxed from a physician's office. Facsimile not valid for C-II prescriptions.

☐ **Cryo/AH** ☐ **Cryo cycle** ☐ **IVF** ☐ **ICSI/AH** ☐ **Recipient (Egg Donor)** ☐ **Egg Donor** ☐ **IUI (partner)** ☐ **IUI (donor)**

Medication Directions	Quantity	Refill
☐ **Antagon Kit** ______	______	______
☐ **Antagon Prefilled Syringes** ______	______	______
250 UG/0.5 ml Single dose ______	______	______
☐ **Cetrotide™** 25 mg ______	______	______
☐ **Cetrotide™** 3 mg ______	______	______
☐ **Doxycycline** 100 mg ______	______	______
☐ **Estrace™** 1 mg ______	______	______
☐ **Estrace™** 2 mg ______	______	______
☐ **Follistim AQ™** 75 IU Vial ______	______	______
☐ **Follistim AQ™** 150 IU Vial ______	______	______
☐ **Follistim AQ™** 300 IU pen ______	______	______
☐ **Follistim AQ™** 600 IU pen ______	______	______
☐ **Follistim AQ™** 900 IU pen ______	______	______
☐ **Gonal-F™** 75 IU Vial ______	______	______
☐ **Gonal-F™ RFF** 300 IU pen ______	______	______
☐ **Gonal-F™ RFF** 450 IU pen ______	______	______
☐ **Gonal-F™ RFF**900 IU pen ______	______	______
☐ **Bravelle™** 75 IU Vial ______	______	______
☐ **Repronex™** 75 IU Vial ______	______	______
☐ **hCG** 10,000 IU Vial ______	______	______
☐ **Ovidrel** 250 mcg ______	______	______
☐ **Heparin** 1 mL Vial (10,000 units/mL) ______	______	______
______	______	______
☐ **Heparin** 5 mL Vial (10,000 units/mL) ______	______	______
______	______	______
☐ **Sharps Package** (Disposal Unit) ______	______	______
______	______	______
☐ **Ultrafine 1cc insulin syringe #** ______	______	______
______	______	______
☐ **20 g 1 1/2" filter needle #** ______	______	______
______	______	______
☐ **22 g 1 1/2" 3 cc syr and needle #** ______	______	______
______	______	______

Medication Directions	Quantity	Refill
☐ **Lupron™ 2 week kit DAW** ______	______	______
☐ **Extra Lupron syringes** ______	______	______
(To be refilled only after request by pt)		
☐ **Leuprolide Acetate 2 week kit** ______	______	______
______	______	______
☐ **Lupron Depot** 3.75 mg PFS ______	______	______
☐ **Lupron Depot** 7.5 mg PFS ______	______	______
☐ **Lupron Microdose** __mcg/___ml __5 ml ______	______	______
______	______	______
☐ **Modicon** 21 day ______	______	______
☐ **Medrol** 4 mg ______	______	______
☐ **Medrol** 8 mg ______	______	______
☐ **Medrol** 16 mg ______	______	______
☐ **Dexamethasone** 25 mg ______	______	______
☐ **Valium** 10 mg ______	______	______
☐ **Prenate vitamins** ______	______	______
☐ **Progesterone** in Sesame Oil 50 mg/ml 10 ml Vial	______	______
______	______	______
☐ **Progesterone Supp.** 50 mg ______	______	______
☐ **Progesterone Supp.** 100 mg ______	______	______
☐ **Progesterone Supp.** 200 mg ______	______	______
☐ **Progesterone Sub. Troches** 200 mg ______	______	______
______	______	______
☐ **Flagyl** 500 mg ______	______	______
☐ **Viagra Vag. Supp.** 25 mg ______	______	______
☐ **Prometrium** 200 mg ______	______	______
☐ **25 g 1 1/2" 3 cc syr and needle #** ______	______	______
______	______	______
☐ **25 g 1 1/2" 3 cc syr and needle #** ______	______	______
______	______	______
☐ **30 g 1 1/2" needle #** ______	______	______
☐ **Alcohol Swabs (box) #** ____ **100** ______	______	______
☐ **Other** ______	______	______
☐ **Other** ______	______	______
☐ **Other** ______	______	______
☐ **Other** ______	______	______

©2006 Walgreens Specialty Pharmacy SP4453-0606