

Specialty Prescription Form

1. PATIENT INFORMATION

Patient Name _____
 Address _____
 Apt. _____
 City, State, ZIP _____
 Home Phone _____ Alternate Phone _____
 DOB _____
 Language Preference: English Spanish Other _____

2. PRESCRIBER INFORMATION

Prescriber's Name _____
 DEA _____
 NPI _____
 Address _____
 City, State, ZIP _____
 Phone _____ Fax _____
 Contact Person _____ Phone _____

3. INSURANCE INFORMATION

Fax copy of prescription and insurance cards with this form, if available (front and back)

Prescription Card: Name of Insurer _____ ID # _____ BIN _____ PCN _____ Group _____
Primary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____
Secondary Insurance: Subscriber _____ ID # _____ Name of Insurer _____ Phone _____

4. DIAGNOSIS AND CLINICAL INFORMATION

Current Pregnancy:

Current gestational age: _____ weeks _____ days

Date recorded: ____ / ____ / ____

Is this a singleton pregnancy? Yes No

Please select all that apply:

- Known, suspected, or history of breast cancer or other hormone sensitive cancer
- Current or history of thrombosis or thromboembolic disorders
- Undiagnosed abnormal vaginal bleeding unrelated to pregnancy
- Cholestatic jaundice or pregnancy
- Liver tumors (benign or malignant)
- Active liver disease
- Uncontrolled hypertension
- None of the above

Diagnosis:

OØ9.211 - Supervision of pregnancy with history of preterm labor, first trimester

Other diagnosis: ICD-10 Code: _____ Descript: _____

Is the patient currently on Makena or 17-hydroxyprogesterone? Yes No

Please list all current medications: _____

Please list all known drug allergies: _____

OB History:

Gestational age of prior pre-term birth: _____ weeks

Has the patient had a previous spontaneous singleton pre-term birth earlier than 37 weeks gestation? Yes No

If so, check indication(s) that apply:

- Multiple gestation Fetal complications Incompetent cervix
- Premature rupture of membranes

5. PRESCRIPTION INFORMATION - *Ancillary supplies and kits will be provided as needed for administration.*

Medication	Dose/Strength	Directions	Quantity	Refills

Ship to: Office Patient **Home health:** Yes No

6. PRESCRIBER SIGNATURE - *stamped signatures are NOT permitted*

X _____ / / _____ X _____ / / _____
 DISPENSE AS WRITTEN DATE PRODUCT SUBSTITUTION PERMITTED DATE

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