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
- ◯ Choleostatic jaundice or pregnancy
- ◯ Liver tumors (benign or malignant)
- ◯ Active liver disease
- ◯ Uncontrolled hypertension
- ◯ None of the above

Diagnosis:

- ◯ OØ9.211 - Supervision of pregancy 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 _____ / / DISPENSE AS WRITTEN DATE

x _____ / / PRODUCT SUBSTITUTION PERMITTED DATE