MDRx fertility pharmacy

Fax: (888) 939-2020
Tel: (800) 515-DRUG

heart for heroes

Physician Name: _____ Center: _____ Tel: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient Enrollment

For office use only

First Name: _____ DOB: _____ Allergies: _____

Address: _____ Email: _____

Home #: (_____) _____ - _____ Work #: (_____) _____ - _____ Cell #: (_____) _____ - _____

My patient and/or his or her spouse is eligible for the Heart for Heroes program by being a medically separated from active duty, Department of Defense Category 2 or 3* injured veteran whose service related injury resulted in infertility requiring assisted reproduction and has no insurance coverage for the eligible Heart for Heroes medications. My patient is a resident of the 50 United States or the District of Columbia.

❑ YES ❑ NO

*Category 2 veterans include those with a serious injury or illness, who are unlikely to return to duty within a time specified by his or her Military Department, and who may be medically separated from the military. Category 3 veterans include those who have a severe or catastrophic injury or illness, who are highly unlikely to return to duty, and who will most likely be medically separated from the military.

Heart for Heroes Eligible Medication**

❑ **MENOPUR 75IU** (menotropins for injection, USP): # ____ vials to dispense

Sig: _____ ____ Refills

❑ **NOVAREL 5,000 units** (chorionic gonadotropin for injection, USP):

_____ vials to dispense

Sig: _____ ____ Refills

❑ 27g ½" 3cc _____ Syringes to be dispensed

❑ 25g ½" 3cc _____ Syringes to be dispensed

❑ **ENDOMETRIN 100mg** (progesterone) insert #____ inserts to be dispensed

Sig: _____ ____ Refills

❑ **GANIRELIX ACETATE 250mcg** (generic) ____ PFS to be dispensed

Sig: _____ ____ Refills

****Please note, ONLY the medications listed in this box are eligible for the Heart for Heroes program. Additional or ancillary medications will be processed through insurance and/or require out-of-pocket expense****

OTHER MEDICATIONS

❑ **Ganirelix Acetate 250mcg/0.5ml (Brand)** ____ **PFS to be dispensed**

Sig: _____ ____ **Refills**

❑ **Leuprolide Acetate** 2 week kit ____ Kits to be dispensed

❑ *Extra Leuprolide Syringes to be refilled only after request by patient*

Sig: _____ ____ Refills

For Leuprolide:

❑ 28g ½" insulin syringe ____ # ____ Refills

For HCG:

❑ 22g 1 ½" 3cc syringe and needle ____ # ____ Refills

❑ 25g 1 ½" needle ____ # ____ Refills

❑ **Other:** _____ ____ To be dispensed

Sig: _____ ____ Refills

❑ **Other:** _____ ____ To be dispensed

Sig: _____ ____ Refills

❑ **Other:** _____ ____ To be dispensed

Sig: _____ ____ Refills

❑ **Other:** _____ ____ To be dispensed

Sig: _____ ____ Refills

❑ **Other:** _____ ____ To be dispensed

Sig: _____ ____ Refills

❑ **Other:** _____ ____ To be dispensed

Sig: _____ ____ Refills

❑ **MDR Sharps Container**

❑ **MDR Instruction Sheets**

❑ **MDR Care Package:** (Sharps container, sterile sponges, band-aids & alcohol swabs)

❑ **Ship to Pt. Home** ❑ **Ship to MD Office**

Today's Date: _____ **Anticipated start date:** _____ Nurses Name (Please print): _____

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

Interchange is mandated unless practitioner writes "NO SUBSTITUTION" in this space: _____

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