Optum

Third Party/Donor Enrollment Form

Optum Specialty Phone: 877-445-6874 | Optum Specialty Fax: 866-306-5231

Specialty Pharmacy Enrollment Form

This form is not a valid prescription in Arizona or Virginia

Please detach before submitting to a pharmacy – tear here

PATIENT INFORMATION

☐ Non-Disclosed (Anonymous) Donor ☐ Directed (Known) Donor
☐ Gestational Carrier ☐ Intended Parent ☐ Surrogate

First Name _____ Last Name _____

Patient ID _____ DOB _____ Gender _____

CYCLE START DATE _____

Address _____

City, State, ZIP _____

Home Phone _____ Alternate Phone _____

Ship to: ☐ Patient ☐ Office ☐ Other _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

MEDICAL INFORMATION (attach additional sheets if needed)

***** Section MUST be completed to process prescription *****

ICD Code _____

Diagnosis _____

Allergies _____

Concomitant Medications

_____

_____

_____

INTENDED PARENT INFORMATION (if applicable)

I.P. Name _____

I.P. DOB _____ I.P. Phone _____

I.P. Gender _____ I.P. Email _____

I.P. Address _____

City, State, ZIP _____

PRESCRIBER INFORMATION

Prescriber's Name _____

DEA _____ NPI _____

Third Party Coordinator Name _____

Coordinator Ext. _____

Address _____

City, State, ZIP _____

Phone _____ Fax _____

Email _____

INSURANCE/CENTER BILLING (attach copy of card if applicable)

Responsible for payment: ☐ Intended Parent ☐ Center

Payment Type: ☐ Self Pay ☐ Insurance Benefits:

☐ Donor ☐ G.C. ☐ Surrogate

Plan Name _____

Cardholder ID _____

BIN _____ PCN _____ Group _____

Prior Authorization Reference Number _____

Address _____

Phone _____ Fax _____

Email _____

PRESCRIPTION INFORMATION (all injectable medications will be dispensed with standard ancillary supplies unless otherwise noted)

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Leuprolide Two Week Kit	☐ 1 mg/0.2 mL	Sig: _____		
☐ Follistim AQ Cartridge	☐ 300 IU ☐ 600 IU ☐ 900 IU	Inject _____ units SQ QD as directed		
☐ Gonal-f RFF	Pen: ☐ 300 IU ☐ 450 IU ☐ 900 IU	Inject _____ units SQ QD as directed		
☐ Gonal-f	MDV: ☐ 450 IU ☐ 1050 IU	Mix and inject _____ units SQ QD as directed		
☐ Menopur	☐ 75 IU	Mix and inject _____ units SQ QD as directed		
☐ Ganirelix PFS	☐ 250 mcg/0.5 mL	Inject 1 PFS SQ QD		
☐ Centrotide Kit	☐ 0.25mg	Mix and inject 0.25mg SQ QD		
☐ Novarel	☐ 5,000 IU	Mix with _____ mL and inject _____ units/mL when directed ☐ IM ☐ SQ		
☐ Pregnyl	☐ 10,000 IU	Mix with _____ mL and inject _____ units/mL when directed ☐ IM ☐ SQ		
☐ Ovidrel PFS	☐ 250 mcg/0.5 mL	Inject # _____ PFS SQ when directed		
☐ Estrance Tablets	☐ 0.5mg ☐ 1mg ☐ 2mg	Take ____ tab(s) ____ times a day as directed ☐ PO ☐ PV		
☐ Vivelle Dot	☐ 0.1 mg/24 hr (#8/Box)	Use as directed up to # _____ patch(es) every _____ day(s)		

Faxed by: _____ Date _____

* Prescriber Authorization: "I authorize this pharmacy and its representatives to act as my authorized agent, including but not limited to, attestations of medical necessity, to secure coverage and initiate the insurance prior authorization process for our shared patient, and to sign any necessary forms, where permitted by law and benefit plan sponsor, on my behalf as my authorized agent, including any required prior authorization forms and the receipt and submission of patient lab values and other patient data that support the prior authorization. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network."

☐ Dispense as written ☐ Product substitution permitted (product will be substituted if DAW not indicated)

Dispense as Written

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

Substitution permitted

Prescriber's Signature _____ Date _____

Electronic or digital signatures not accepted.

CONFIDENTIALITY STATEMENT: This communication is intended for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure under applicable law. If the reader of this communication is not the intended recipient or the employee or agent responsible for delivery of the communication, you are hereby notified that any dissemination, distribution, or copying of the communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone.

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Prior Authorization Reference Number _____

Address _____

Phone _____ Fax _____

Email _____

PRESCRIPTION INFORMATION (all injectable medications will be dispensed with standard ancillary supplies unless otherwise noted)

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Progesterone 50mg/ml in Sesame Oil	Compound type (if applicable) ☐ 50 mg/mL ☐ 100 mg/mL	Inject _____ mL(s) IM _____ times a day		
☐ Progesterone compound	☐ Olive Oil	Inject _____ mL(s) IM _____ times a day		
☐ Endometrin Vaginal Inserts	☐ 100 mg	Use 1 insert PV _____ times a day		
☐ Crinone 8%		Use 1 insert PV _____ times a day		
☐ Progesterone capsules	☐ 100mg ☐ 200mg	Use _____ cap(s) ☐ PO _____ times a day ☐ PV _____ times a day		
☐ Medrol Tablets	☐ 4mg ☐ 8mg ☐ 16mg	Take _____ tab(s) PO _____ times a day		
☐ Other				
☐ Other				

Faxed by: _____ Date _____

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