



@RareSpecialtyRx | RareSpecialtyRx.com | #RareSpecialtyRx

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398 W Grand Ave | Rahway, NJ 07065

Today's Date: _____

Date Needed: _____

Patient Name: _____ Date of Birth: ____/____/____ Gender: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Allergies/Notes: _____

(PLEASE ATTACH CLINICAL NOTES/LABS AND COPIES OF PATIENT'S INSURANCE CARDS)

Primary Insurance: _____ ID#: _____ Group#: _____ Insured's Name: _____
Employer: _____ City: _____ State: _____ Phone: _____

ICD-10 Diagnosis Code: ☐ Z79.890 Hormone Replacement Therapy ☐ E28.319 Primary Ovarian Failure ☐ E29.1 Testicular Hypofunction
☐ E34.9 Endocrine Disorder, Unspecified ☐ E29.8 Other Testicular Dysfunction ☐ E30.0 Delayed Puberty ☐ 30.8 Other Disorders of Puberty
☐ E89.6 Postprocedural Hypoestrogenism ☐ F64.0 Transsexualism ☐ Other: _____
Previously treated for this condition? ☐ Yes ☐ No Medication(s) failed: _____

HRT ORDER FORM

ESTROGEN

☐ ESTRADIOL VALERATE ☐ 50mg/5ml ☐ 100mg/5ml ☐ 200mg/5ml

SIG: Inject _____ intramuscularly weekly

QTY: _____ ml Refills: _____

☐ ESTRADIOL ☐ 0.5mg oral tablet ☐ 1mg oral tablet ☐ 2mg oral tablet

SIG: Take _____ by mouth once daily

QTY: _____ tablets Refills: _____

☐ CLIMARA PATCH ☐ 0.025mg/day ☐ 0.05mg/day ☐ 0.075mg/day ☐ 0.1mg/day
SIG: Apply one patch to the skin once weekly.

QTY: _____ patches Refills: _____

ANDROGEN

☐ TESTOSTERONE CYPIONATE ☐ 100mg/ml injection ☐ 200mg/ml injection

Please send electronic prescription.

☐ TESTOSTERONE ☐ 1% gel ☐ 1.62% gel ☐ 2% gel ☐ 2.5% gel

Please send electronic prescription.

ANTI-ANDROGEN

☐ BICALUTAMIDE ☐ 50mg tablet

SIG: Take _____ tablet by mouth once daily.

QTY: _____ tablets Refills: _____

PROGESTERONE

☐ PROGESTERONE ☐ 100mg oral capsule ☐ 200mg oral capsule

SIG: Take _____ by mouth once daily.

QTY: _____ capsules Refills: _____

☐ MINOXIDIL ☐ 2.5mg oral tablet

SIG: Take _____ tablet by mouth once daily.

QTY: _____ tablets Refills: _____

OTHER

Name: _____ Strength: _____

SIG: _____

QTY: _____ Refills: _____

This prescription will be filled generically unless the prescriber writes "DAW" here: _____

Prescriber Name/Practice: _____

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

Phone: _____ Fax: _____ Office Contact: _____

License#: _____ NPI#: _____ UPIN#: _____ DEA#: _____

Prescriber's Signature (signature required, no stamps): _____ Date: _____

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