RARE SPECIALTY PHARMACY
@RareSpecialtyRx | RareSpecialtyRx.com | #RareSpecialtyRx

P: (855) 713-7049 | F: (888) 509-1154
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: _____