COMPASSIONATE CORPS PRODUCT REQUEST FORM

Fax application to: 1-866-882-2900

PHYSICIAN INFORMATION

THE COMPASSIONATE CORPS PROGRAM WAS ESTABLISHED FOR VETERANS WHO HAVE FERTILITY ISSUES DUE TO SERVICE-RELATED INJURIES AND THEIR SPOUSES. YOUR SIGNATURE BELOW DENOTES THAT YOU ARE CERTIFYING THAT THE PATIENT OR THEIR SIGNIFICANT OTHER FITS THESE PROGRAM PARAMETERS.

PHYSICIAN'S NAME	PHYSICIAN'S TITLE		
FACILITY NAME			
MAILING ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	**DEA/NPI NUMBER	FAX NUMBER	
OFFICE CONTACT PERSON	OFFICE CONTACT PERSON'S TITLE		

PATIENT INFORMATION

PATIENT NAME			
DATE OF BIRTH	GENDER ☐ Male ☐ Female	By providing your email address, you consent to receive additional mailings from the Compassionate Corps Program. E-MAIL	
HOME PHONE	MOBILE PHONE		
MAILING ADDRESS	CITY	STATE	ZIP CODE
ANTICIPATED CYCLE START DATE	PREFERRED PRODUCT DELIVERY DATE		

Products may take up to **seven days** to ship from receipt of completed form.

Is the patient/significant other a veteran who has fertility issues due to wounds received in the line of duty? ☐ Yes ☐ No

Does the patient/significant other require assisted reproductive technology (like IVF)? ☐ Yes ☐ No

PRODUCT REQUEST

Intended use for requested products: **Assisted reproductive technologies (ART)**

Product	Number of units*
☐ Gonal-f® (follitropin alfa injection) [either Gonal-f® 450 IU Multi-Dose or Gonal-f® RFF Redi-ject 450 IU (follitropin alfa for injection)]	7†
☐ Cetrotide® 0.25 mg Injection (cetrorelix acetate for injection)	6 Cetrotide® 0.25 mg Vials
☐ Ovidrel® PreFilled Syringe (choriogonadotropin alfa injection)	2 Ovidrel® PreFilled Syringes

*Program is valid for a maximum of 2 cycles per calendar year

†Maximum quantity per patient of 3150 IU (7 Units of either Gonal-f® RFF Redi-ject 450 IU or Gonal-f® Multi-Dose 450 IU)

I certify that the information provided in this application is complete and accurate to the best of my knowledge, that the product ordered hereunder is medically indicated for this patient and I am aware of the risks and benefits associated with the use of Gonal-f® RFF Redi-ject™ (follitropin alfa injection), Cetrotide® (cetrorelix acetate for injection), and Ovidrel® (choriogonadotropin alfa injection). I further certify that all units of any product shipped to me pursuant to this application will be provided to the above-named patient only, for his or her treatment, and will not be sold or otherwise distributed and that no patient or third party shall be charged for such product. Additionally, no units of product will be submitted for Medicare, Medicaid, Tricare, the VA, DOD, or any public or private third-party reimbursement, or returned for credit. I understand eligibility under this Program is subject to EMD Serono, Inc.'s approval and the patient's continuing compliance with all eligibility requirements, as set by EMD Serono, Inc. from time to time. I agree to allow EMD Serono, Inc., or its authorized agent(s), to review medical, financial, and insurance records for this patient at any time for the purposes of verifying the patient's eligibility status for the Program and the patient's receipt of any product(s) provided to him or her through the Program.

Prescriber's Signature: _____ Date: _____
(Photocopies or stamped signatures will not be accepted)

Fertility LifeLines™ Authorization: _____ Date: _____

Patient ID: _____ Approval Date: _____ Expiration Date: _____