

1 PATIENT INFORMATION

Patient's Name _____

Date of Birth _____ Male Female Last 4 digits of SSN _____

Street Address _____ Apt# _____

City _____ State _____ Zip _____

Parent/Guardian (if applicable) _____

Home Phone _____ Work Phone _____

Cell Phone _____ Evening Phone _____

E-mail address _____

Insurance Company Name _____

Insurance Company Phone No. _____

Insured's Name _____

Insured's Employer _____

Relationship to Patient _____

Identification No. _____ Policy/Group No. _____

Prescription Card No Yes If Yes, Carrier _____

Policy No. _____ Group No. _____

Is patient eligible for Medicare? No Yes **Please attach front and back copy of patient's insurance cards, if available.**

2 PRESCRIBER INFORMATION

Prescriber's Name _____

Office Contact _____

Clinic / Hospital Affiliation _____

Street Address _____ Suite # _____

City _____ State _____ Zip _____

Phone _____ Fax _____

NPI No. _____ License No. _____

DEA No. _____

Physician Medicaid UPIN No. _____

MD Specialty _____

To reach your team, call toll-free **1 877 218-0410**.
Please fax completed form to the Growth Disorder team
1 888 355-6682.

3 CLINICAL INFORMATION

PRIMARY DIAGNOSIS (CHECK ONE) Adult Pediatric

Diagnosis: _____

Weight (kg) _____ Height (cm) _____

Please attach information for Growth Disorder Diagnosis:

- **GH Stimulation Test Results**
- **IGF-I Results**
- **Other Laboratory Results**
- **Medical History**
- **Drug Profile**

PRESCRIPTION

<input type="checkbox"/> Genotropin Pen® 5/5.8 mg Cartridge	<input type="checkbox"/> Norditropin Pen/Cartridge® 5 mg
<input type="checkbox"/> Genotropin Mixer Device® 5/5.8 mg Cartridge	<input type="checkbox"/> Norditropin Pen/Cartridge® 15 mg
<input type="checkbox"/> Genotropin Pen® 12/13.8 mg Cartridge	<input type="checkbox"/> Nutropin® 5 mg Vial
<input type="checkbox"/> Genotropin Mixer Device® 12/13.8 mg Cartridge	<input type="checkbox"/> Nutropin® 10 mg Vial
<input type="checkbox"/> Genotropin Mini Quick® _____ mg	<input type="checkbox"/> Nutropin AQ® 10 mg/2 mL Vial
<input type="checkbox"/> Humatrope® 5 mg Vial	<input type="checkbox"/> Nutropin AQ® 10 mg/2mL Pen/Cartridge
<input type="checkbox"/> Humatrope® 6 mg Cartridge	<input type="checkbox"/> Nutropin AQ® 20 mg/2 mL Pen/Cartridge
<input type="checkbox"/> Humatrope® 12 mg Cartridge	<input type="checkbox"/> Omnitrope® 1.5 mg vial
<input type="checkbox"/> Humatrope® 24 mg Cartridge	<input type="checkbox"/> Omnitrope® 5.8 mg vial
<input type="checkbox"/> Increlex® 40 mg/4mL	<input type="checkbox"/> Saizen® 5 mg Vial
<input type="checkbox"/> Lupron® _____ mg	<input type="checkbox"/> Saizen® 5 mg with Cool-Click
<input type="checkbox"/> Lupron Depot® _____ mg	<input type="checkbox"/> Saizen® 8.8 mg Vial
<input type="checkbox"/> Lupron Depot Ped® _____ mg	<input type="checkbox"/> Saizen® 8.8 mg with Cool-Click
<input type="checkbox"/> Nordiflex Disposable Pen® 5 mg	<input type="checkbox"/> Saizen® One Click 8.8 mg
<input type="checkbox"/> Nordiflex Disposable Pen® 10 mg	<input type="checkbox"/> Serostim®
<input type="checkbox"/> Nordiflex Disposable Pen® 15 mg	<input type="checkbox"/> Tev-Tropin® 5 mg Vial

Any other device used? (check one if applicable) Injectease Genjects

Note: Prescription to include all necessary ancillary supplies (i.e. needles, syringes and pen devices)

Diluent Amount _____ Injection Volume _____

Dose _____ mg _____ days/week Dose _____ mg / kg / wk

Dispense _____ months supply Refill _____ times or through _____ (date)

Specific administration supply (gauge) _____

Note to TN prescribers - Quantity must be written in both numerals and words (ex. 3(three) doses)

SHIP DRUG TO: Physician's Office Patient's Home
(If shipped to physician's office, physician accepts on behalf of patient for administration in office.)

Injection Training Yes No

By: MD Office Alternate Agency _____
 Accredo Agency Phone _____

I certify that the prescribed Growth Hormone Product is not for cosmetic, anti-aging or athletic enhancement purposes and is medically necessary for the replacement of endogenous Growth Hormone secondary to GH deficiency and I will be supervising the patient's treatment accordingly.

Prescriber's Printed Name _____

Prescriber's Signature (sign below) _____ Date _____

Dispense as Written Substitution Allowed

(Physician attests this is his/her legal signature. **NO STAMPS**)