Growth Hormone Enrollment Form

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6 Simple steps to submitting a referral

1 PATIENT INFORMATION

(Complete the following or include demographic sheet)

Patient Name: ______
Address: ______
City, State, Zip: ______
Primary Phone: ______ DOB: ______
Alternate Phone: ______ Gender: ☐Male ☐Female
E-mail: ______
Last Four of SS #: ______ Primary Language: ______

2 PRESCRIBER INFORMATION

Prescriber's Name: ______
State License #: ______ NPI #: ______
DEA #: ______
Group or Hospital: ______
Address: ______
City, State Zip: ______
Phone: ______ Fax: ______
Contact Person: ______ Phone: ______

3 INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______ Ship to: ☐ Patient ☐Office ☐ Other: ______

Date of Diagnosis: ______
☐ 783.43 Idiopathic Short Stature (ISS)
☐ 783.43 Primary IGF-1 Deficiency
☐ 253.2 Panhypopituitarism
☐ 253.3 GHD - Adult
☐ 253.3 GHD - Pediatric
☐ 259.0 Pubertal Dosing
☐ 259.4 Small Gestational Age
☐ 585 Chronic Renal Insufficiency (CRI)
☐ 759.81 Prader-Willi Syndrome
☐ 759.89 Noonan's Syndrome
☐ 758.6 Turner Syndrome
☐ Other (Please indicate ICD-9 code & description): ______

Height: ______ cm/inches Weight: ______ kg/lbs Visit Date: ______ Next Clinic Visit: ______
Allergies: ______ IGF-1: ______ BP3: ______
Has patient previously been on growth hormone? ☐ Yes ☐ No If yes, start date & product: ______
Does patient have an ☐ Active/ ☐ History of tumor/malignancy? ☐ Yes ☐No If yes, how long has regrowth been absent? ______ years
Concomitant Medications/Comments: ______
Provocative Test Results: Test #1 ☐ N/A Agent: ______ Date: ______ Peak Value: ______ Units: ______
Test #2 ☐ N/A Agent: ______ Date: ______ Peak Value: ______ Units: ______
Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary ☐ Yes ☐ No Agency of choice: ______
Injection training provided by Manufacture Program ☐ Yes ☐ No
Injection training is not necessary. Date training occurred: ______ Reason: ☐MD office trained patient ☐Patient already independent ☐Referred by MD office to alt. trainer

5 PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Genotropin®	Intra-Mix® cartridges: ☐1.5 ☐5.8 Pen Cartridges: ☐5 ☐12 MiniQuick®: ______ mg			
☐ Genotropin® Pen	Size: ☐ 5 ☐ 12	Use as directed with Genotropin® pen cartridges.	1	
☐ Genotropin® Mixer Device	N/A	Use as directed with Genotropin® cartridges.	1	
☐ Humatrope®	Cartridge kits: ☐6mg ☐12mg ☐24mg Vial kit: ☐5mg			
☐ HumatroPen®	☐HumatroPen® 6mg ☐HumatroPen® 12mg ☐HumatroPen® 24mg	Use as directed with Humatrope® cartridges.	1	
☐ Increlex™	40mg/4ml vial			
☐ Norditropin®				
☐ FlexPro®	☐ 5mg ☐ 10mg ☐ 15mg	Use as directed.		
☐ Nordiflex®	☐ 30mg	Use as directed.		
☐ Nutropin®	Vial kits: ☐5mg ☐10mg			
☐ Nutropin AQ®	Nutropin AQ Pen® cartridge kit: ☐10mg ☐20mg Vial kit: ☐ 5mg ☐10mg			
☐ Nutropin AQ Pen®	N/A	Use as directed with Nutropin AQ Pen® cartridges.	1	
☐ Nutropin AQ NuSpin	☐5mg ☐10mg ☐ 20mg	Use as directed.		
☐ Omnitrope®	☐5.8mg/ vial ☐5mg/1.5ml cartridges ☐10mg/1.5ml cartridges			
☐ Omnitrope® Pen	Size: ☐ 5 ☐ 10	Use as directed.		
☐ Saizen®	click.easy cartridge: ☐8.8mg vial kits: ☐5mg ☐8.8mg			
	☐ cool.click™ 2 device ☐ cool.click™ device ☐ easypod™ ☐ one-click™ device	Use as directed.	1	
☐ Tev-Tropin™	☐ 5mg vial			
☐ Tjet Injector System				

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

X ______ (Date)
DISPENSE AS WRITTEN

X ______ (Date)
PRODUCT SUBSTITUTION PERMITTED

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Growth Hormone 011013