



Fax: \_\_\_\_\_  
Phone: \_\_\_\_\_

# Growth Hormone Enrollment Form

## PATIENT INFORMATION

Please complete the following or **send patient demographic sheet**

Patient Name \_\_\_\_\_  
Address \_\_\_\_\_  
Address 2 \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_  
DOB \_\_\_\_\_ Last Four of SS# \_\_\_\_\_ Gender \_\_\_\_\_  
Language Preference:  English  Spanish  Other \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Group/Hospital \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Must fax a copy of patient's insurance card including both sides)

Prior Authorization Reference number \_\_\_\_\_

## MEDICAL INFORMATION (Section must be completed to process prescription) (Attach separate sheet if needed)

**Diagnosis** — Please include diagnosis name with ICD-10 code

E23.0 Hypopituitarism  N18.9 Chronic kidney disease, unspecified  
 Other Diagnosis: ICD-10 Code \_\_\_\_\_  
Description \_\_\_\_\_  
Date of Diagnosis \_\_\_\_\_  
IGF-1 \_\_\_\_\_ BP3 \_\_\_\_\_

### Provocative Test Results:

Agent \_\_\_\_\_ Date \_\_\_\_\_ Peak Value \_\_\_\_\_ Units \_\_\_\_\_  
Agent \_\_\_\_\_ Date \_\_\_\_\_ Peak Value \_\_\_\_\_ Units \_\_\_\_\_  
Start Date \_\_\_\_\_ Review Date \_\_\_\_\_

**Additional Information**

Therapy:  New  Reauthorization  Restart

Weight \_\_\_\_\_ kg/lbs Height \_\_\_\_\_ cm/in  
Allergies \_\_\_\_\_  
Lab Data \_\_\_\_\_  
Prior Therapies \_\_\_\_\_  
Concomitant Medications \_\_\_\_\_  
Additional Comments \_\_\_\_\_  
Injection Training Required:  Yes  No

## PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> Genotropin®				
<input type="checkbox"/> Humatrope®				
<input type="checkbox"/> Norditropin®				
<input type="checkbox"/> Nutropin AQ®				
<input type="checkbox"/> Omnitrope®				
<input type="checkbox"/> Saizen®				
<input type="checkbox"/> Serostim®				
<input type="checkbox"/> Zorbtive®				

Ship to:  Patient  Office  Other \_\_\_\_\_ Date \_\_\_\_\_ Needs by Date \_\_\_\_\_

**\*Prescriber Authorization:** I authorize this pharmacy and its representatives to act as my authorized agent to secure coverage and initiate the insurance prior authorization process for my patient(s), and to sign any necessary forms on my behalf as my authorized agent, including the receipt of any required prior authorization forms and the receipt and submission of patient lab values and other patient data. In the event that this pharmacy determines that it is unable to fulfill this prescription, I further authorize this pharmacy to forward this information and any related materials related to coverage of the product to another pharmacy of the patient's choice or in the patient's insurer's provider network.

Product Substitution permitted  Dispense as Written

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_

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