



# GROWTH HORMONE ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.HealthDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

|                            |   |
|----------------------------|---|
| <b>PATIENT INFORMATION</b> | Patient: _____ Caregiver: _____   |
|                            | DOB: _____ Male Female Weight: _____ kgs or lbs (check one) Height: _____ in or cm (check one) Recorded Date: _____ |
|                            | Address: _____ City: _____ State: _____ Zip: _____  |
|                            | Best Phone #: _____ Cell Alternate Phone #: _____ Cell Email: _____   |
|                            | Allergies: _____ Latex Allergy: Yes No  |
|                            | ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____                         |

## PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION

|   |  |
|---|--|
| <b>MEDICAL ASSESSMENT</b>   | 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: _____                           |  |

## PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

| MEDICATION   | DOSE/STRENGTH  | DIRECTIONS                                     | QUANTITY | REFILLS |
|--------------|--|--|----------|---------|
| Genotropin®  | Pen Cartridges: 5 12 MiniQuick®: _____ mg                | _____  | _____    | _____   |
| Humatrope®   | Cartridge kits: 6mg 12mg 24mg<br>Vial kit: 5mg           | _____  | _____    | _____   |
| HumatroPen®  | HumatroPen® 6mg HumatroPen® 12mg<br>HumatroPen® 24mg     | Use as directed with Humatrope® Pen Cartridges | 1        | _____   |
| Norditropin® | _____  | _____  | _____    | _____   |
| FlexPro®     | 5mg 10mg 15mg  | _____  | _____    | _____   |
| Nordiflex®   | 30mg   | _____  | _____    | _____   |
| Skytrofa®    | _____  | _____  | _____    | _____   |
| Omnitrope®   | 5.8mg/Vial 5mg/1.5ml Cartridges<br>10mg/1.5ml Cartridges | _____  | _____    | _____   |
| Tev-Tropin™  | 5mg Vial   | _____  | _____    | _____   |
| Saizen®      | Click.easy 8.8mg<br>Vial kits: 5mg 8.8mg                 | Use as directed                                | _____    | _____   |
| Other        | _____  | _____  | _____    | _____   |

|                 |                   |                 |            |                         |
|-----------------|-------------------|-----------------|------------|-------------------------|
| <b>SUPPLIES</b> | Novotwist needles | 32G 5mm 30G 8mm | Novofine   | 32G 6mm 30G 8mm         |
|                 | Autocover         | 30G 8mm         | BD Needles | 32G 4mm 31G 5mm 31G 8mm |

## INJECTION TRAINING: OFFICE TO COORDINATE HEALTHDYNE SPECIALTY TO COORDINATE

|  |   |
|--|---|
| <b>PRESCRIBER INFORMATION</b>                                      | Anticipated Start Date: _____ Prescriber Specialty: _____   |
|  | Ship to: Patient Physician Clinic Other: _____  |
|  | Fax #: _____ Contact Name: _____  |
|  | Office Address: _____ City: _____ State: _____ Zip: _____   |
|  | The terms and conditions posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.HealthDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. |
|  | I understand that HealthDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.  |
| Prescriber's Name: _____ Prescriber's Signature: _____ Date: _____ |   |
| Use substitution Dispense as written DEA# _____                    |   |

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