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.

PATIENT INFORMATION

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: _____

MEDICAL ASSESSMENT

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

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

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Genotropin®	Pen Cartridges: ☐ 5 ☐ 12 MiniQuick®: _____ mg	_____	_____	_____
☐ Humatrope®	Cartridge kits: ☐ 6mg ☐ 12mg ☐ 24mg Vial kit: ☐ 5mg	_____	_____	_____
☐ HumatroPen®	HumatroPen® ☐ 6mg HumatroPen® ☐ 12mg 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 ☐ 10mg/1.5ml Cartridges	_____	_____	_____
☐ Tev-Tropin™	☐ 5mg Vial	_____	_____	_____
☐ Saizen®	Click.easy ☐ 8.8mg Vial kits: ☐ 5mg ☐ 8.8mg	Use as directed	_____	_____
☐ Other				

SUPPLIES

Novotwist needles	☐ 32G 5mm	☐ 30G 8mm	Novofine	☐ 32G 6mm	☐ 30G 8mm
Autocover	☐ 30G 8mm		BD Needles	☐ 32G 4mm	☐ 31G 5mm ☐ 31G 8mm

PRESCRIBER INFORMATION

INJECTION TRAINING: OFFICE TO COORDINATE HEALTHDYNE SPECIALTY TO COORDINATE

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.

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☐ 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# _____