

<input type="checkbox"/> New to Therapy
<input type="checkbox"/> Current Therapy

## Patient Information

Patient Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: M or F Caregiver: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Please attach copy of front and back of patient's prescription ins. card(s) if applicable  
 Insurance Company Name: \_\_\_\_\_  
 Insurance Company Phone: \_\_\_\_\_  
 Policy holder: \_\_\_\_\_  
 Policy holder Employer: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 ID# \_\_\_\_\_ Group# \_\_\_\_\_  
 RxBIN: \_\_\_\_\_ RxPCN: \_\_\_\_\_

## Prescriber Information

Practice/ Organization Name: \_\_\_\_\_  
 Prescriber Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_  
 DEA# \_\_\_\_\_ NPI# \_\_\_\_\_  
 License#: \_\_\_\_\_ Medicaid UPIN#: \_\_\_\_\_  
 Physician Specialty: \_\_\_\_\_  
 Date Shipment Needed: \_\_\_\_\_  
 Ship to:  Patient  Prescriber  Other: \_\_\_\_\_  
 Shipment Address: \_\_\_\_\_ Attn: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
*If shipped to the prescriber's office, Prescriber accepts on behalf of patient for administration in office.*

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## Clinical Information and Prescription

Diagnosis:  E23.0 Hypopituitarism  E34.3 Short Stature due to Endocrine Disorder  
 R62.52 Short Stature (child)  \_\_\_\_\_ Description: \_\_\_\_\_  
 Date of Diagnosis or Years with Disease: \_\_\_\_\_  
 Patients Allergies: \_\_\_\_\_  
 Latex allergy:  Yes  No Patient Weight: \_\_\_\_\_ Patient Height: \_\_\_\_\_  
 Medical History -**Please attach all lab/test results/treatment plans**  
 Comorbidities: \_\_\_\_\_  
 Previous and Current Medication Use:  
 \_\_\_\_\_  Current  Failed  Intolerant  Other: \_\_\_\_\_ Dates used: \_\_\_\_\_  
 \_\_\_\_\_  Current  Failed  Intolerant  Other: \_\_\_\_\_ Dates used: \_\_\_\_\_  
 Expected First Dose Date: \_\_\_\_\_ Injection Instruction needed:  Yes  No

**Genotropin® (somatropin [rDNA] for injection)**  
 Cartridge (for use in PEN or MIXER Device):  5mg  12mg  
 MiniQuick Device:  0.2mg  0.4mg  0.6mg  0.8mg  1.0mg  1.2mg  
 1.4mg  1.6mg  1.8mg  2.0mg

**Humatrope® (somatropin [rDNA] for injection)**  
 Cartridge for use in the HumatroPen®:  6mg  12mg  24mg  
 5mg Vials

**Norditropin® (somatropin [rDNA] for injection) FlexPro® Pen Device**  
 5mg/1.5ml  10mg/1.5ml  15mg/1.5ml  30mg/3ml

**Omnitrope® (somatropin [rDNA] for injection)**  
 Pen Device:  5mg  10mg  
 5.8mg Vial

**Saizen® (somatropin [rDNA] for injection)**  
 Vial w/ bacteriostatic water for Inj 0.3%:  5mg  8.8mg  
 8.8mg click.easy® cartridge with Sterile Water for Inj 0.3%

Dose: Inject \_\_\_\_\_ mg subcutaneously \_\_\_\_\_ days per week; or  
 Inject \_\_\_\_\_ mg/kg subcutaneously \_\_\_\_\_ days per week  
 Quantity Prescribed:  QS 30 days  Other: \_\_\_\_ Refills Authorized:  0  1  3  6  11  \_\_\_\_\_  
 Prescriber Signature: X \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_