

**MEDICATIONS**

**Patient Information**

Please type or print clearly.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ ZIP Code \_\_\_\_\_

DOB \_\_\_\_\_

Home Phone w/area code \_\_\_\_\_

Work Phone w/area code \_\_\_\_\_

Spouse Name/Parent(s)/Other \_\_\_\_\_

**Insurance Information**       Major Medical       Rx Benefit

Please attach a copy of card(s) if possible.

Primary Insurer \_\_\_\_\_

Cardholder \_\_\_\_\_

DOB \_\_\_\_\_ Cardholder ID # \_\_\_\_\_

Group # \_\_\_\_\_ RxCARD ID # \_\_\_\_\_

RxBin # \_\_\_\_\_ RxGroup # \_\_\_\_\_

Phone w/area code \_\_\_\_\_ Fax w/area code \_\_\_\_\_

**Medical Assessment**

Allergies \_\_\_\_\_

Patient Weight (kg/lbs) \_\_\_\_\_

Patient Height \_\_\_\_\_

Height/Weight Date \_\_\_\_\_

Date of Most Recent MD Visit \_\_\_\_\_

**Physician Information**

MD Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone w/area code \_\_\_\_\_

Fax w/area code \_\_\_\_\_

UPIN \_\_\_\_\_ DEA # \_\_\_\_\_

**Please acknowledge receipt of this fax.**

**PHYSICIAN SIGNATURE REQUIRED**

I certify that the therapy is medically necessary and the information on this form is accurate to the best of my knowledge.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Form faxed by \_\_\_\_\_

Print Full Name

**Genotropin®**

Prefilled Syringe (*dispensed in multiples of 7*)

0.2 mg                       1.0 mg                       1.8 mg

0.4 mg                       1.2 mg                       2.0 mg

0.6 mg                       1.4 mg

0.8 mg                       1.6 mg

5.8 mg cartridge (Pen® 5)

13.8 mg cartridge (Pen® 12)

**Humatrope®**

Pen Cartridge

6 mg                       12 mg                       24 mg

5 mg vial

**Norditropin NordiFlex® Delivery Pen**

5 mg/1.5 mL                       10 mg/1.5 mL                       15 mg/1.5 mL

**Norditropin® Pen Cartridge**

5 mg/1.5 mL                       15 mg/1.5 mL

**Nutropin®**

5 mg vial                       10 mg vial

**Nutropin AQ®**

10 mg/2 mL pen cartridge                       10 mg/2 mL vial

**Saizen®**

5 mg vial                       8.8 mg vial

**click.easy™ with Saizen®** (*uses one.click™ device*)

8.8 mg cartridge

**Serostim® Vials** (*dispensed in multiples of 7*)

4 mg                       5 mg                       6 mg

**Tev-Tropin™** 5 mg vial

**Zorbtive®** 8.8 mg vial (*dispensed in multiples of 7*)

**SIG**

Reconstitute with \_\_\_\_\_ cc of diluent per vial

Inject \_\_\_\_\_ cc ( \_\_\_\_\_ mg) SQ \_\_\_\_\_ days per wk

Other (i.e., "clicks") \_\_\_\_\_

Quantity \_\_\_\_\_ **OR** Day Supply \_\_\_\_\_

Refills (1 year refills) \_\_\_\_\_

**CONFIDENTIAL HEALTH INFORMATION:** Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.

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Drug names are the property of their respective owners.



**SUPPLIES**

**Dilutional Syringes**

- B-D 3cc 25g 5/8" syr disp (100)
- CC \_\_\_\_\_ Gauge \_\_\_\_\_ Length \_\_\_\_\_

Directions UTD  
 Other \_\_\_\_\_  
Quantity \_\_\_\_\_ Refills (1 year refill) \_\_\_\_\_

**Dental Needles**

Quantity \_\_\_\_\_ Refills (1 year refill) \_\_\_\_\_

**Swabs (B-D Alcohol Swabs)**

Quantity Q100 or 1 Box Refills (1 year refill) \_\_\_\_\_

**Sharps Container (Large)**

Quantity 1 Refills (1 year refill) \_\_\_\_\_

**Injectional Syringes** \_\_\_\_\_

CC \_\_\_\_\_  
Gauge \_\_\_\_\_  
Length \_\_\_\_\_  
 Directions UTD  
 Other \_\_\_\_\_  
Quantity \_\_\_\_\_ Refills (1 year refill) \_\_\_\_\_

**Pen Needles**

- B-D Pen Needles (Q100)
  - Original 29g 1/2"
  - UFIII 31g 5/16" (short)
  - UFIII 31g 3/16" (mini)
- Novofine Disp Pen Needles (Q100)
  - 30g 5/16"
  - 31g 3/16"
- Other \_\_\_\_\_

Directions UTD

Quantity \_\_\_\_\_ Refills (1 year refill) \_\_\_\_\_

**Pen Device**

- Genotropin® Pen 5
- Genotropin® Pen 12
- Humatrope® Pen
- Inject-Ease®
- Nutropin AQ® Pen
- NordiPen Pen® 5
- NordiPen Pen® 15
- Saizen® cool.click™
- Saizen® one.click™ for use with click.easy™

Directions Use as instructed for growth hormone

Other \_\_\_\_\_  
Quantity \_\_\_\_\_ Refills (1 year refill) \_\_\_\_\_

