

Growth Hormone Enrollment Form

Patients must bring an original prescription to the pharmacy. Faxed prescriptions will only be accepted from a prescribing practitioner.

PATIENT INFORMATION Deliver Here
 (Complete the following or include demographic sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Primary Phone: _____ DOB: _____
 Alternate Phone: _____ Gender: Male Female
 E-mail: _____
 Primary Language: _____

PRESCRIBER INFORMATION Deliver Here

Prescriber's Name: _____
 State License #: _____ NPI #: _____
 DEA #: _____
 Address: _____
 City, State Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____ Phone: _____

INSURANCE INFORMATION If available, please fax copy of prescription insurance cards with this form (front and back).

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Genotropin®	MiniQuick®: _____ mg			
<input type="checkbox"/> Omnitrope®	<input type="checkbox"/> 5.8mg/ vial			
<input type="checkbox"/> Norditropin®				
<input type="checkbox"/> FlexPro®	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg			

Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

X

PHYSICIAN SIGNATURE REQUIRED

X

DISPENSE AS WRITTEN

(Date)

PRODUCT SUBSTITUTION PERMITTED

(Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee.