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
☐ Genotropin®	MiniQuick®: _____ mg			
☐ Omnitrope®	☐ 5.8mg/ vial			
☐ Norditropin®				
☐ FlexPro®	☐ 5mg ☐ 10mg ☐ 15mg			

☐ Patient is interested in patient support programs

Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

X _____

DISPENSE AS WRITTEN (Date)

X _____

PRODUCT SUBSTITUTION PERMITTED (Date)