

Customer Information

Customer 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 insurance 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.

Privacy & Confidentiality of Information Notice: This communication may contain non-public, confidential, or legally privileged information intended for the sole use of the designated recipient(s). If you are not the intended recipient, or have received this communication in error, please notify the sender immediately by reply email or by telephone at the number stated above and delete all copies of this communication, including any attachments, without reading them or saving them to disk. If you are the intended recipient, you must secure the contents of this communication in accordance with all applicable state or federal requirements related to the privacy and confidentiality of information, including the HIPAA Privacy guidelines.

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: ____/____/____