

# Prescription & Enrollment Form Growth Disorders



(800) 962-6339 Office  
(866) 755-6339 Fax

### Patient Information

_____	_____
Last Name	First Name
_____	_____
Social Security #	Date of Birth
_____	_____
Parent or Guardian	
_____	_____
Home Phone	Other Contact Phone
_____	_____
Home Address	
_____	
City, State, Zip	

### Insured Information

_____	
Primary Insurance (Fax copy of card – both sides)	
_____	
Subscribers Name	Relationship to Patient
_____	_____
Policy #	Group #
_____	_____
Primary Insurance Phone	
_____	
Prescription Card (Fax copy of card – both sides)	
_____	
Carrier	Policy #
_____	_____

### DIAGNOSIS/MEDICAL INFORMATION (Please specify primary and secondary diagnoses) Adult Pediatric

<input type="checkbox"/> 253.2 Panhypopituitarism	<input type="checkbox"/> 253.3 GHD-Adult	<input type="checkbox"/> Other ICD 9
Bone Age: <input type="checkbox"/> weeks <input type="checkbox"/> months	Weight: <input type="checkbox"/> lbs <input type="checkbox"/> kgs	Height: <input type="checkbox"/> in <input type="checkbox"/> cm
Age: <input type="checkbox"/> weeks <input type="checkbox"/> months	GH result for stimulation test:	
Growth Velocity: (please include growth chart)	Is patient new to therapy? <input type="checkbox"/> yes <input type="checkbox"/> no	Date of Diagnosis: _____ Training Required? <input type="checkbox"/> yes <input type="checkbox"/> no

### PRESCRIPTION INFORMATION

Medication	Dose	Frequency	Quantity	Refills
<input type="checkbox"/> Genotropin®	<input type="checkbox"/> 5 mg/cart. <input type="checkbox"/> 12 mg/cart. <input type="checkbox"/> Mini Quick _____mg			
<input type="checkbox"/> Humatrope®	<input type="checkbox"/> 5 mg/vial <input type="checkbox"/> 6 mg/cart. <input type="checkbox"/> 12 mg/cart. <input type="checkbox"/> 24 mg/cart.			
<input type="checkbox"/> Norditropin®	<input type="checkbox"/> 5 mg/cart. <input type="checkbox"/> 15 mg/cart. <input type="checkbox"/> 5 mg Nordiflex <input type="checkbox"/> 10 mg Nordiflex <input type="checkbox"/> 15 mg Nordiflex			
<input type="checkbox"/> Nutropin®	<input type="checkbox"/> 5 mg/vial <input type="checkbox"/> 10 mg/vial			
<input type="checkbox"/> Nutropin® AQ	<input type="checkbox"/> 10 mg/vial <input type="checkbox"/> 10 mg/cart. <input type="checkbox"/> 20 mg/cart. <input type="checkbox"/> 5 mg/NuSpin <input type="checkbox"/> 10 mg/NuSpin <input type="checkbox"/> 20 mg/NuSpin			
<input type="checkbox"/> Omnitrope®	<input type="checkbox"/> 5 mg/cart. <input type="checkbox"/> 10 mg/ cart. <input type="checkbox"/> 1 – 1.5 mg/vial <input type="checkbox"/> 8 – 5.8 mg/vials			
<input type="checkbox"/> Saizen®	<input type="checkbox"/> 5 mg/vial <input type="checkbox"/> 8.8 mg/vial <input type="checkbox"/> 5 mg w/Cool-Click <input type="checkbox"/> 8.8 mg w/Cool-Click <input type="checkbox"/> 8.8 mg One Click			
<input type="checkbox"/> Tev-Tropin®	<input type="checkbox"/> 5mg/vial			

### DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other	Address _____ City/State/Zip _____	Date Medication Needed
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Physician's Name (Please Print)

Physician's DEA#

Physician's Address

Phone

Fax

Physician's Signature

Date

License #

NPI #

Dr.'s Office Contact Name

Contact Phone #

**Fax completed form to Medex BioCare (866) 755-6339**

updated 10-19-09