



Human Growth Hormone Order Form
 2506 Lakeland Drive, Suite 201, Jackson, Mississippi 39232
 Pharmacy phone: (866) 420-4041 Pharmacy fax: (601) 420-4040
 www.transcriptpharmacy.com

Patient Information

Patient name _____
 Address _____
 City _____ State _____ Zip _____
 Home phone _____ Cell _____
 DOB _____ SSN _____
 Drug allergies _____ Male Female

Prescriber Information

Prescriber name _____ Lic# _____
 DEA# _____ Medical Specialty _____
 Practice name _____
 Address _____ Suite _____
 City _____ State _____ Zip _____
 Office Phone _____ Fax _____

Insurance, Medicare or Medicaid Information

Primary Insurance _____ Secondary Insurance (*If applicable*) _____
 Policy # _____ Group _____ Policy # _____ Group _____
 Insurance phone _____ Insurance phone _____
 Prescription Drug Coverage: Company _____ Phone _____
 RXGRP# _____ RXBIN# _____ PCN/ID# (if avail.) _____
 COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARD(S)

Medical Necessity / Clinical Information

<input type="radio"/> GHD Pediatric 253.3 <input type="radio"/> Noonan's Synd. 759.89 <input type="radio"/> GHD Adult 253.3 <input type="radio"/> Turner Synd. 758.6 <input type="radio"/> Panhypopituitarism 253.2 <input type="radio"/> Idiopathic Short Stature (ISS) 783.43 <input type="radio"/> Prader Willi Synd. 759.81 <input type="radio"/> Chronic Renal Insufficiency 585 <input type="radio"/> Other: _____ ICD-9: _____	Patient Height _____ Patient Weight _____ lbs? kg? Has patient received HGH previously? <input type="radio"/> Yes <input type="radio"/> No Does patient have active malignancy? <input type="radio"/> Yes <input type="radio"/> No Does patient have history of malignancy? <input type="radio"/> Yes <input type="radio"/> No Provide info for "yes" answers _____
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GH Stimulation Test Results: Agent: _____ Peak GH _____ ng/ml Comments _____ Date _____
 GH Stimulation Test Results: Agent: _____ Peak GH _____ ng/ml Comments _____ Date _____

Drug Name	Strength	Directions for Use	Qty	Refills
<input type="radio"/> Genotropin				
<input type="radio"/> Humatrope				
<input type="radio"/> Norditropin				
<input type="radio"/> Omnitrope				
<input type="radio"/> Saizen				
<input type="radio"/> Tev-Tropin				
<i>Other Medication</i>				

Deliver to: Patient's home OMD's office 1st dose to MD's office, remaining refills to patient home Injection training needed? Yes No

We authorize Transcript Pharmacy, its employees and agents, to assist with delegated prior authorization requests to the fullest extent allowable by law and insurer guidelines.

 Prescriber name or signature Office Contact Name (Nurse, MA, Other) Preferred phone number & extension Date