

# Growth Hormone Enrollment Form



2506 Lakeland Drive  
Flowood, MS 39232  
Phone: 866-420-4041  
Fax: 601-420-4040  
www.transcriptpharmacy.com

Please fax the completed form to:  
**601-420-4040**

Delivery Need By: \_\_\_\_\_ Delivery to:  Patients Home  Physician's Office  Other

| PATIENT INFORMATION  | PRESCRIBER INFORMATION |
|--|------------------------|
| Patient Name: <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Prescriber Name:       |
| Address:   | Address:               |
| City, State, Zip:  | City, State, Zip:      |
| Phone:   | Phone:                 |
| Date of Birth:   | Fax:                   |
| Social Security Number:  | DEA/NPI#:              |

## INSURANCE – PLEASE FAX COPY OF PRESCRIPTION CARD FRONT & BACK CLINICAL INFORMATION

|  |   |
|--|---|
| Diagnosis:                                   | Has the patient been treated previously for this condition?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| ICD-10 Code:                                 | Medications failed:   |
| Height: _____ inches      Weight: _____ lbs. | Medications on:   |
| Allergies:                                   | Other notes:  |

## PRESCRIPTION INFORMATION

| Medication:  | Dosage/Strength:  | Directions:   | Quantity                 | Refills |
|--|---|---|--------------------------|---------|
| Genotropin® Miniquick  | <input type="checkbox"/> ___ mg MiniQuick   | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Genotropin Cartridge   | <input type="checkbox"/> 5mg <input type="checkbox"/> 12mg  | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Humatrope  | <input type="checkbox"/> 6mg cartridge kit <input type="checkbox"/> 24mg cartridge kit<br><input type="checkbox"/> 12mg cartridge kit <input type="checkbox"/> 5mg vial kit | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| HumatroPen (if needed for administration)                                  | <input type="checkbox"/> 6 mg <input type="checkbox"/> 12mg<br><input type="checkbox"/> 24mg  | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Norditropin FlexPro  | <input type="checkbox"/> 5mg <input type="checkbox"/> 15mg<br><input type="checkbox"/> 10mg <input type="checkbox"/> 30mg   | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Nutropin AQ NuSpin   | <input type="checkbox"/> 5mg <input type="checkbox"/> 20mg<br><input type="checkbox"/> 10mg   | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Omnitrope  | <input type="checkbox"/> 5mg/1.5mL cartridge <input type="checkbox"/> 5.8mg/vial<br><input type="checkbox"/> 10mg/1.5mL cartridge   | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Saizen   | <input type="checkbox"/> 5mg vial kit<br><input type="checkbox"/> 8.8mg vial kit<br><input type="checkbox"/> 8.8 mg click easy cartridge                                    | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Zomacton   | <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg  | <input type="checkbox"/> ___ mg SQ ___ days per week                    | <input type="checkbox"/> |         |
| Other:   |   |   |                          |         |
| <input type="checkbox"/> Patient is interested in patient support programs |   | <input type="checkbox"/> Ancillary supplies provided for administration |                          |         |

Office Contact Name: \_\_\_\_\_ Preferred phone number & extension: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**E-Scribe Rx and Fax this Form to 601-420-4040**

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