Growth Hormone Enrollment Form

Please fax the completed form to:

601-420-4040

TRANSCRIPT PHARMACY

Signature Care Program

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

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

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ☐ Female ☐ 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? ☐ Yes ☐ No
ICD-10 Code:	Medications failed:
Height: feet inches Weight: lbs.	Medications on:
Allergies:	Other notes:

PRESCRIPTION INFORMATION

Medication:	Dosage/Strength:	Directions:	Quantity	Refills
Genotropin® Miniquick	☐ ___ mg MiniQuick	☐ ___ mg SQ ____ days per week	☐	
Genotropin Cartridge	☐ 5mg ☐ 12mg	☐ ___ mg SQ ____ days per week	☐	
Humatrope	☐ 6mg cartridge kit ☐ 24mg cartridge kit ☐ 12mg cartridge kit ☐ 5mg vial kit	☐ ___ mg SQ ____ days per week	☐	
HumatroPen (if needed for administration)	☐ 6 mg ☐ 12mg ☐ 24mg	☐ ___ mg SQ ____ days per week	☐	
Norditropin FlexPro	☐ 5mg ☐ 15mg ☐ 10mg ☐ 30mg	☐ ___ mg SQ ____ days per week	☐	
Nutropin AQ NuSpin	☐ 5mg ☐ 20mg ☐ 10mg	☐ ___ mg SQ ____ days per week	☐	
Omnitrope	☐ 5mg/1.5mL cartridge ☐ 5.8mg/vial ☐ 10mg/1.5mL cartridge	☐ ___ mg SQ ____ days per week	☐	
Saizen	☐ 5mg vial kit ☐ 8.8mg vial kit ☐ 8.8 mg click easy cartridge	☐ ___ mg SQ ____ days per week	☐	
Zomacton	☐ 5mg ☐ 10mg	☐ ___ mg SQ ____ days per week	☐	
Other:				

☐ Patient is interested in patient support programs ☐ 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