Growth Hormone
Prescription &
Pharmacy Intake Form

Phone: 1-718-762-7400
Fax: 1-718-762-7404
Toll Free: 1-888-93-EVERS

Provider Representative | **Phone** | **Date Needed** | **Ship to** ☐ Specialty Care Center ☐ Patient's Home ☐ Prescriber's Office ☐ Other____________

PATIENT INFORMATION

Patient Name: ______________ DOB: ________ ☐ Male ☐ Female
Address: ______________
City: ________ State: ______ Zip Code: ________
Phone # (Daytime): ________ Phone # (Evening): ________
E-mail Address: ______________
Insurance Provider (**Please include copy of front and back of card**): ______________
ID #: ________ Policy/Group #: ________ Phone #: ________
Name of Insured: ________ Employer: ________
Relationship to Patient: ☐ Self ☐ Other: ________ ☐ Patient is Eligible for Medicare
Prescription Card: ☐ Yes ☐ No Carrier: ________ Policy/Group #: ________

CLINICAL ASSESSMENT

☐ Patient is New to Therapy
☐ Patient is Currently on Therapy
(Start Date:__________)

Primary ICD-9 and Condition Description:
____

Current Weight:________ Date: ________
Current Height:________ Date: ________

Bone Age: ________
Growth Velocity: ________

Other Health Conditions:________
____

Allergies:________
____

Concomitant Medications:________
____
____

PRESCRIPTION INFORMATION

Medication	Dose/Directions/Freq	Qty	Refills
Genotropin® Strength: ☐ Cartridge ☐ Miniquik PFS			
Humatrope® Strength: ☐ Vial ☐ Cartridge			
Lupron Depot-Ped® Strength:			
Norditropin® Nordiflex® Pen ☐ 5 mg/1.5 mL ☐ 10 mg/1.5 mL ☐ 15 mg/1.5 mL ☐ 30 mg/3 mL			
Norditropin Flexpro® ☐ 5 mg/1.5 mL ☐ 10 mg/1.5 mL ☐ 15 mg/1.5 mL			
Nutropin® Vial ☐ 5 mg Vial ☐ 10 mg Vial			
Nutropin AQ® Vial/Cartridge ☐ 10 mg Vial ☐ 10 mg Cartridge			
Nutropin AQ® Nuspin Pen ☐ 5 mg ☐ 10 mg ☐ 20 mg			
Omnitrope® ☐ 5.8 mg Vial ☐ 5 mg/1.5 mL Pen ☐ 10 mg/1.5 mL Pen			
Saizen® ☐ 5 mg Vial ☐ 8.8 mg Vial ☐ 8.8 mg Click Easy™ Cartridge			
Tev-Tropin® ☐ 5 mg Vial			
☐ Other: ________			

PRESCRIBER INFORMATION

Prescriber's Name: ______________ Practice/Facility Name: ______________
Address: ______________ Office Contact: ________
City: ________ State: ______ Zip Code: ________
Phone #: ________ Fax: ________ Best Time to Call: ________
State License #: ________ DEA #: ________ NPI#: ________ Medicaid UPIN #: ________

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**," or your state specific required language to prohibit substitution: ______________

I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's Signature Required: ______________ Date: ________

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that don't require authorization. You are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws.
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Drug names are the property of their respective owners.