# Growth Hormone Enrollment and Prescription Form

**Tel: 844-443-6879 Fax: 844-329-2447**

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Medina, Ohio.

## PATIENT INFORMATION

Patient Name ____________________

DOB ___/___/______ SSN ____________ Gender ______

Weight ________ Height ________ Phone ____________

Address ____________________

City, State, Zip ____________________

Cell Phone ____________ E-Mail ____________

PLEASE PROVIDE COPY OF PATIENT'S PRESCRIPTION INSURANCE CARD WITH ENROLLMENT FORM

Insurance Co. Name ____________________

Insurance Co. Phone ____________ Group# ________

Policy Holder Name ____________________

Policy Holder Employer ____________________

Relationship to Patient ____________________

ID# ____________ RxBIN ________ PCN ________

## PRESCRIBER INFORMATION

Prescriber's Name ____________________

Practice Name ____________________

State License# ____________ UPIN ____________

DEA ____________ NPI ____________

Address ____________________

City, State, Zip ____________________

Phone ____________ Fax ____________

Office Contact Person ____________________

Prescription Date ____________ Date Needed ____________

**With my signature on this form, I also authorize use of Gentry Health's Services which includes serving as my prior authorization designated agent in dealing with medical and prescription insurance companies, and co-pay assistance foundations.**

**Prescriber Signature** ____________________

Ship to: ☐ Patient ☐ Prescriber's Office ☐ Discount Drug Mart

## PLEASE PROVIDE ALL RELEVANT CHART NOTES FOR INSURANCE PURPOSES

**Medical Information (DO NOT COMPLETE IF CHART NOTES ARE PROVIDED)**

Diagnosis ____________________ Date of Diagnosis ____________

ICD-10 Code: ☐ E23.0 - Hypopituitarism ☐ N18.9 - Chronic Kidney Disease, unspecified

☐ OTHER DIAGNOSIS ICD-10 Code: ____________________

Any prior therapies tried? ____________________

IGF-1 ________ BP3 ________

Drug Allergies ____________________ Latex Allergy? ☐ YES ☐ NO

Any additional Supplies Needed? ____________________

Any other relevant medical info? ____________________

**Provocative Test Results**

Agent ____________ Date ________ Peak Value ________ Units ________

Agent ____________ Date ________ Peak Value ________ Units ________

Start Date ____________ Review Date ____________

Any Additional Relevant Lab Values? ____________________

Concommitant Medications ____________________

## PRESCRIPTION INFORMATION *(DAW requests must be handwritten)*

☐ **Genotropin® (somatropin)** ☐ Cartridge ☐ Miniquick® Strength: ____________

Directions: ____________________ QTY: ________ Refills ________

☐ **Humatrope® (somatropin)** ☐ Cartridge Kit ☐ Vial Strength: ____________

Directions: ____________________ QTY: ________ Refills ________

☐ **Lupron Depot® (leuprolide acetate)** ☐ 3.75mg ☐ 7.5mg ☐ 11.25mg ☐ 22.5mg ☐ 30mg ☐ 45mg

Directions: ____________________ QTY: ________ Refills ________

☐ **Lupron Depot-PED® (leuprolide acetate)** ☐ 7.5mg ☐ 11.25mg ☐ 15mg ☐ 30mg

Directions: ____________________ QTY: ________ Refills ________

☐ **Norditropin® (somatropin)** ☐ Flexpro® Prefilled Pen Strength: ________ ☐ NordiFlex® Prefilled Pen 30mg/3ml

Directions: ____________________ QTY: ________ Refills ________

☐ **Omnitrope® (somatropin)** ☐ 5mg Cartridge ☐ 10mg Cartridge ☐ 5.8mg Vials

Directions: ____________________ QTY: ________ Refills ________

☐ **Saizen® (somatropin)** ☐ 5mg Vial ☐ 8.8mg Vial ☐ 8.8mg Click Easy® Cartridge

Directions: ____________________ QTY: ________ Refills ________

## ADDITIONAL SUPPORTIVE MEDICATION

| Medication Name and Dosage Form | Strength | Directions | Qty | Refills |
|---|---|---|---|---|
| | | | | |
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CONFIDENTIALITY NOTICE: THE INFORMATION IN THIS TRANSMITTAL IS CONFIDENTIAL AND INTENDED ONLY FOR THE RECIPIENT LISTED ABOVE. IF YOU ARE NEITHER THE INTENDED RECIPIENT NOR A PERSON RESPONSIBLE FOR DELIVERING THIS TRANSMITTAL TO THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY DISTRIBUTION OR COPYING OF THIS TRANSMITTAL IS PROHIBITED. IF YOU RECEIVE THIS TRANSMITTAL IN ERROR, PLEASE IMMEDIATELY NOTIFY US AND RETURN THE TRANSMITTAL TO US AT OUR EXPENSE.