Growth Hormone Enrollment and Prescription Form

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

ePrescribe to our pharmacy at "GENTRY HEALTH SERVICES" in Avon Lake, 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 _____
DEA _____ NPI _____
Address _____
City, State, Zip _____
Phone _____ Fax _____
Office Contact Person _____
Office Contact EMAIL _____
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