BLUEGRASS PHARMACY | GROWTH HORMONE ENROLLMENT FORM

BLUEGRASS Pharmacy
A Member of the Wellpartner Family

FAX FORM TO: 1.866.233.8317 | **PHONE:** 1.855.492.0817 | **EMAIL:** contact@bluegrass-rx.com

Complete the following or include demographic sheet.

1. PATIENT INFORMATION

Name:
Address:
City, State, ZIP:
Primary Phone: - - DOB: / /
Alternate Phone: - - Gender:
Email:
Primary Language: Last Four of SSN:

2. PRESCRIBER INFORMATION

Name:
DEA #: NPI #: State Lic. #:
Group or Hospital:
Address:
City, State, Zip:
Phone: - - Fax: - -
Contact Person: Phone: - -

3. INSURANCE INFORMATION

*Fax copy of **prescription** and **insurance cards** with this form, if available (front and back)*

Primary Insurance Company Name:
Primary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

Secondary Insurance Company Name:
Secondary Cardholder Name:
Relationship: ◯ Self ◯ Spouse/Partner ◯ Child/Dependent
Phone: - - Member ID: Group #:

4. DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: / / Ship to: ◯ Patient ◯ Office ◯ Other:

Date of Diagnosis: / /

◯ E23.Ø Hypopituitarism
◯ E3Ø.Ø Delayed puberty
◯ E34.3 Short stature due to endocrine disorder
◯ N18.9 Chronic kidney disease, unspecified
◯ Q96.9 Turner's syndrome
◯ Q87.1 Congenital malformation syndromes predominately associated with short stature
◯ R62.52 Short stature (child)
◯ Other:

Height (in/cm): Weight (lb/kg):

Has patient previously been on growth hormone? ◯ Yes ◯ No
If yes, start date and product: / /

Does patient have active, or history of, tumor/malgnancy? ◯ Yes ◯ No
If history, how long has grown been absent? _____ years

Provocative test results: Test #1 ◯ N/A Agent: _____ Date: / / Peak value: _____ Units: _____
Test #2 ◯ N/A Agent: _____ Date: / / Peak value: _____ Units: _____

Has patient received injection training? ◯ Yes ◯ No

Last clinic visit: / / Next visit: / / IGF-1: BP3:

Allergies:

Concomitant Medications:

5. PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
◯ Genotropin™	Intra-Mix cartridges: ◯ 5.8 mg Pen cartridges: ◯ 5 mg ◯ 12 mg MiniQuick: _____ mg			
◯ Pen	Size: ◯ 5 mg ◯ 12 mg			
◯ Mixer Device	N/A			
◯ Humatrope™	Cartridge kits: ◯ 6 mg ◯ 12 mg ◯ 24 mg Vial kit: ◯ 5 mg			
◯ HumatroPen	◯ 6 mg ◯ 12 mg ◯ 24 mg			
◯ Increlex™ (LD)*	(LD)* This is a limited distribution drug that requires additional handling. Please call (1.855.492.0817) for more information.			
◯ Norditropin				
◯ FlexPro™	◯ 5 mg/1.5 ml ◯ 10 mg/1.5 ml ◯ 15 mg/1.5 ml			
◯ Nordiflex™	◯ 5 mg/1.5 ml ◯ 10 mg/1.5 ml ◯ 15 mg/1.5 ml ◯ 30 mg/3 ml			
◯ Nutropin™	Vial kit: ◯ 5 mg ◯ 10 mg			
◯ Nutropin™ AQ	Vial/Cartridge: ◯ 10 mg vial ◯ 10 mg cartridge ◯ 20 mg cartridge Nuspin Pen: ◯ 5 mg ◯ 10 mg ◯ 20 mg			
◯ Omnitrope™	◯ 5.8 mg vial ◯ 5 mg/1.5 ml cartridge ◯ 10 mg/1.5 ml cartridge			
◯ Pen	Size: ◯ 5 mg ◯ 10 mg			
◯ Saizen™	Click Easy™ Cartridge: ◯ 8.8 mg Vial kit: ◯ 5 mg ◯ 8.8 mg			
	◯ cool.click 2 device ◯ cool.click device ◯ easypod ◯ one-click device			
◯ Tev-Tropin™	◯ 5 mg vial			

Ancillary supplies and kits will be provided as needed for administration.

6. PRESCRIBER SIGNATURE

X / /
DISPENSE AS WRITTEN DATE

X / /
PRODUCT SUBSTITUTION PERMITTED DATE