WELLPARTNER PHARMACY | GROWTH HORMONE ENROLLMENT FORM

Wellpartner

FAX FORM TO: 1.877.597.3070 | **PHONE:** 1.800.473.3516 | **EMAIL:** specialty@wellpartner.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 (1.800.473.3516) 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