GROWTH HORMONE AGENTS

PHONE: 888-903-7453 • FAX: 888-958-2831 • www.praxisrx.com

PraxisRx

PATIENT INFORMATION

Patient:_____ Caregiver: _____
DOB:_____ ☐ Male or ☐ Female Weight:_____ ☐ kgs or ☐ lbs (check one) Allergies:_____
Address:_____ City:_____ State:_____ Zip:_____
Primary Phone #:_____ ☐ Cell Alternate Phone #:_____ ☐ Cell
Email:_____

CLINICAL INFORMATION

Date of Diagnosis: _____ ICD-10 Code: _____ Description: _____
Height: _____ cm/inches Weight: _____ kg/lbs Recorded Date: _____
IGF-1: _____ BP3: _____
Has patient previously been on growth hormone? ☐ Yes ☐ No If yes, start date & product: _____
Does patient have an Active/History of tumor/malignancy? ☐ Yes ☐ No If yes, how long has regrowth been absent? _____ years
Concomitant Medications/Comments: _____
Provocative Test Results: Test #1 ☐ N/A Agent: _____ Date: _____ Peak Value: _____ Units: _____
Test #2 ☐ N/A Agent: _____ Date: _____ Peak Value: _____ Units: _____

PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Genotropin®	Pen Cartridges: ☐ 5 ☐ 12 MiniQuick®: _____mg			
☐ Humatrope®	Cartridge kits: ☐ 6mg ☐ 12mg ☐ 24mg Vial kit: ☐ 5mg			
☐ HumatroPen®	HumatroPen® ☐ 6mg HumatroPen® ☐ 12mg HumatroPen® ☐ 24mg	Use as directed with Humatrope® Pen Cartridges	1	
☐ Norditropin®				
☐ FlexPro®	☐ 5mg ☐ 10mg ☐ 15mg			
☐ Nordiflex®	☐ 30mg			
☐ Nutropin AQ®	Nutropin AQ Pen® cartridge kit: ☐ 10mg ☐ 20mg			
☐ Nutropin AQ Pen®	N/A	Use as directed with Nutropin AQ Pen® Cartridges	1	
☐ Nutropin AQ NuSpin	☐ 5mg ☐ 10mg ☐ 20mg			
☐ Omnitrope®	☐ 5.8mg/Vial ☐ 5mg/1.5ml Cartridges ☐ 10mg/1.5ml Cartridges			
☐ Tev-Tropin™	☐ 5mg Vial			
☐ Saizen®	Click.easy ☐ 8.8mg Vial kits: ☐ 5mg ☐ 8.8mg	Use as directed		

SUPPLIES

Novotwist needles	☐ 32G 5mm	☐ 30G 8mm	Novofine	☐ 32G 6mm	☐ 30G 8mm
Autocover	☐ 30G 8mm		BD Needles	☐ 32G 4mm	☐ 31G 5mm ☐ 31G 8mm

PRESCRIBER INFORMATION

Anticipated Start Date: _____ Prescriber Specialty: _____
Ship to: ☐ Patient ☐ Physician ☐ Clinic ☐ Other:_____
Prescriber: _____ NPI #: _____ DEA#_____ Phone #: _____
Fax #: _____ Contact Name: _____
Office Address: _____ City: _____ State: _____ Zip: _____

I authorize PraxisRx and its representatives to act as an agent to initiate/execute the insurance prior authorization process, coordinate and receive patient lab values, and coordinate injection training.

Physician's Signature: _____ Date: _____