## **GROWTH HORMONE AGENTS**



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

PATIENT INFORMATION				
Patient:		Caregiver:		
DOB:				
Address:		City:	State: Zip	):
	Cell	Alternate Phone #:		Cell
Email:				
CLINICAL INFORMATION				
Date of Diagnosis:	ICD-10 Code: Descripti			
Height: cm/inche				
	BP3:			
Has patient previously been on growth hormone?				
Does patient have an Active/History of tumor/malignancy? 🗌 Yes 🔲 No If yes, how long has regrowth been absent? years				
Concomitant Medications/Comments:				
		Date:		
	Test #2 N/A Agent:	Date:	Peak Value:	Units:
PRESCRIPTION INFORMATION				
MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Genotropin <sup>®</sup>	Pen Cartridges:			
☐ Humatrope®	Cartridge kits: ☐ 6mg ☐ 12mg ☐ 24mg Vial kit: ☐ 5mg			
☐ HumatroPen®	HumatroPen® ☐ 6mg HumatroPen® ☐ 12mg HumatroPen® ☐ 24mg	Use as directed with Humatrope® Pen Cartr	idges 1	
☐ Norditropin®				
☐ FlexPro®	□ 5mg □ 10mg □ 15mg			
☐ Nordiflex®	□ 30mg			
☐ Nutropin AQ®	Nutropin AQ Pen <sup>®</sup> cartridge kit: ☐ 10mg ☐ 20mg			
☐ Nutropin AQ Pen®	N/A	Use as directed with Nutropin AQ Pen® Cart	iridges 1	
☐ Nutropin AQ NuSpin	□ 5mg □ 10mg □ 20mg			
☐ Omnitrope®	☐ 5.8mg/Vial ☐ 5mg/1.5ml Cartridges ☐ 10mg/1.5ml Cartridges			
☐ Tev-Tropin <sup>™</sup>	☐ 5mg Vial			
☐ Saizen®	Click.easy	Use as directed		
SUPPLIES				
Novotwist needles	□ 32G 5mm □ 30G 8mm	Novofine ☐ 32G 6mm	n □ 30G 8mm	
Autocover	□ 30G 8mm	BD Needles 32G 4mn	n □ 31G 5mm	□ 31G 8mm
PRESCRIBER INFORMATION				
Anticipated Start Date: Prescriber Specialty:				
Ship to: Patient Physician Clinic Other:				
	NPI #:			
Fax #: Contact Name:				
			State:	
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:				

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