CIENEGA PHARMACY

Growth Hormone Prescription Form

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DATE:______________ NEEDS BY DATE:______________ SHIP TO: ❑ PATIENT ❑ OFFICE ❑ OTHER ______________

PATIENT INFO		PRESCRIBER INFO		
Patient Name		Prescriber Name		
Address		DEA #	NPI #	License #
City, State, Zip		Address		
Main Phone	Alternate Phone	City, State, Zip		
Social Security #		Phone	Fax	
Date of Birth	❑ Male ❑ Female	Contact Person		

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Diagnosis: ❑Growth Hormone Deficiency ❑Short Bowel Syndrome ❑Growth failure d/t PWS (Prader-Willi Syndrome) ❑Central precocious puberty
❑Growth Failure d/t Chronic Renal Insufficiency up to the time of renal transplantation ❑Short Stature associated with Turner Syndrome ❑Idiopathic Short Stature
❑Othe_r ______________

MEDICAL ASSESSMENT:

- Has patient been treated previously for this condition? ❑ Yes ❑ No Medication(s_): ______________
- Is patient currently on therapy? ❑ Yes ❑ No Medication(s_): ______________
- Will patient stop taking the above medication(s) before starting the new medication? ❑ Yes ❑ No; if yes, what is the wash out period? ______________
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile): ______________

PRESCRIPTION INFORMATION

❑**Genotropin**(two-chamber cartridge) ❑1.5 mg ❑ 5.8 mg* ❑ 13.8mg* ❑**Enroll in Pfizer BRIDGE Program**
Genotropin Miniquick: ❑ 0.2 mg ❑ 0.4 mg ❑ 0.6 mg ❑0.8 mg ❑1 mg ❑1.2 mg ❑ 1.4 mg ❑1.6 mg ❑1.8 mg ❑2 mg
Sig______________ Qty:________ Refills:________

❑**Humatrope**powder with diluent: ❑5 mg/vial ❑6 mg cartridge ❑12 mg cartridge ❑24 mg cartridge ❑**Enroll in Humatrope HRC Program**
Sig______________ Qty:________ Refills:________

❑**Increlex** 40mg/4 ml ❑**Enroll in TerciCARE® Program**
Sig______________ Qty:________ Refills:________
(Note: maximum dose of 0.12 mg/kg SQ twice daily, injection should be administered shortly (20 min) before or after a meal or snack)

❑**Lupron Depot-Ped** ❑7.5 mg ❑11.25 mg ❑15 mg
Sig______________ Qty:________ Refills:________

❑**Norditropin** ❑**Enroll in NordiCARE® Program**
NordiPen injection Pen & Cartridge: ❑15mg/1.5mL
Norditropin NordiFlex ❑30mg/1.5mL
Norditropin FlexPro ❑5mg/1.5mL ❑10mg/1.5mL ❑15mg/1.5mL
Sig______________ Qty:________ Refills:________

❑**Saizen** powder with diluent: ❑5 mg/vial* ❑8.8 mg/vial* ❑Click easy Cartridge 8.8 mg ❑**Enroll in Connections For Growth**
Sig______________ Qty:________ Refills:________

❑**Tev-Tropin** powder with diluent: ❑5 mg/vial ❑**Enroll in Growth Solutions**
Sig______________ Qty:________ Refills:________

❑**Zorbtive** powder with diluent: ❑ 8.8 mg/vial* *(Note: max dose : 8 mg/day, max duration: 4 weeks)* ❑**Enroll in SeroCare**
Sig______________ Qty:________ Refills:________

❑**Other**______________ Qty:________ Refills:________
*Diluent contains: Benzyl Alcohol (multi-dose vial)

By signing this form, Cienega Pharmacy and it's staff are authorized to serve as your prior authorization designated agent for medical and prescription insurance companies.

______________ ______________
Prescriber's Signature (no stamps) Date

If Brand required check ❑ DAW

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