



GROWTH HORMONE ENROLLMENT & PRESCRIPTION FORM

PHONE: 800-641-8475 FAX: 800-530-8589 WEB: www.WellDyneSpecialty.com

To submit a new prescription via eRx, use NPI 1902298805. Faxed prescriptions will only be accepted from prescribing practitioners. Patients may not submit prescriptions via fax and must submit original copies in person or via the mail. Prescribers are reminded patients may choose any pharmacy of their choice.

PATIENT INFORMATION	Patient: _____ Caregiver: _____
	DOB: _____ Male Female Weight: _____ kgs or lbs (check one) Height: _____ in or cm (check one) Recorded Date: _____
	Address: _____ City: _____ State: _____ Zip: _____
	Best Phone #: _____ Cell Alternate Phone #: _____ Cell Email: _____
	Allergies: _____ Latex Allergy: Yes No
	ICD-10 Code for requested therapy: _____ ICD-10 Code(s) for other medical conditions: _____

MEDICAL ASSESSMENT	PLEASE FAX COPY OF ALL INSURANCE CARDS (FRONT & BACK) INCLUDING MEDICAL AND PRESCRIPTION	
	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: _____		

PLEASE PROVIDE ALL CLINICAL INFORMATION INCLUDING LAB RESULTS ON ALL FORMS

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	_____	_____	
Other					

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	INJECTION TRAINING:		OFFICE TO COORDINATE		WELLDYNE SPECIALTY TO COORDINATE	
	Anticipated Start Date: _____		Prescriber Specialty: _____			
	Ship to: Patient Physician Clinic Other: _____					
	Fax #: _____		Contact Name: _____			
	Office Address: _____		City: _____		State: _____ Zip: _____	
	<p>The terms and conditions posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference. The data privacy terms posted at www.WellDyneSpecialty.com have been read by the person signing this form and are incorporated into this document by reference.</p> <p>I understand that WellDyne Specialty may transfer this prescription to another pharmacy as an agent of the prescriber if unable to dispense.</p>					
Prescriber's Name: _____		Prescriber's Signature: _____		Date: _____		
Use substitution		Dispense as written				

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