



OMNITROPE® PATIENT ENROLLMENT

1 PATIENT INFORMATION (Please complete the following information) Patient Name: _____ DOB: _____ Gender: [] Male [] Female Address: _____ City: _____ State: _____ Zip: _____ Emergency Contact: _____ Phone: _____ [] Please attach demographic information

2 INSURANCE [] Please attach front and back of patient's insurance card, prescription benefit card, and/or Medicaid card. Primary Insurance: _____ ID: _____ Group: _____ (if applicable) Secondary Insurance: _____ ID: _____ Group: _____ (if applicable)

3 PATIENT DIAGNOSIS PEDIATRIC: [] Growth Hormone Deficiency (E23.0) [] Prader-Willi Syndrome (Q87.11) [] Small for gestational age (P05.10) [] Turner's Syndrome (Q96.9) [] Idiopathic Short Stature (R62.52) ADULT: Adult onset growth hormone deficiency (E23.0) Adult growth hormone deficiency with onset in childhood (E23.0)

4 MEDICAL ASSESSMENT Current Height (in cm): _____ Current Weight (in kg): _____ Allergies: _____ Current Medication list: _____

5 PRESCRIPTION INFORMATION DRUG: Omnitrope PEN 5mg/1.5ml Omnitrope PEN 10mg/1.5ml DOSE: _____ mg/injection _____ days per week QS 30-Day QS 90-Day REFILL X _____ SUPPLIES: Pen Needle for Injection: 31G; 8MM Pen Needle 31G; 5MM Pen Needle Qty: 100 REFILL x _____ Additional Supplies: [] Sharps Container [] Alcohol Swabs [] Device (if first fill ONLY)

6 PRESCRIBER INFORMATION Prescriber Name: _____ NPI: _____ DEA: _____ Address: _____ City: _____ State: _____ Zip: _____ Office Contact: _____ Phone: _____ Fax: _____

7 PHYSICIAN AUTHORIZATION Physician's Signature _____ Date of Signature _____ May Substitute May NOT Substitute IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. In no event should such material be read or retained by anyone other than the named addressee, except by the express authority of the sender to the named addressee.