elixir
SPECIALTY PHARMACY

Growth Disorder Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

☐ **New to Therapy**
☐ **Current Therapy**

Patient Information

Patient Name: _____
Date of Birth: _____ Sex: M☐or F☐ Caregiver:_____
Address: _____
City: _____State:_____Zip:_____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ E-mail:_____
Please attach copy of front and back of patient's prescription ins. card(s) if applicable
Insurance Company Name: _____
Insurance Company Phone: _____
Policy holder:_____
Policy holder Employer:_____
Relationship to Patient:_____
ID# _____Group#_____
RxBIN: _____RxPCN:_____

Clinical Information and Prescription

Diagnosis: ☐ E23.0 Hypopituitarism ☐ E34.3 Short Stature due to Endocrine Disorder
☐ R62.52 Short Stature (child) ☐ _ _ _ . _ _ Description: _____
Date of Diagnosis or Years with Disease: _____
Patients Allergies: _____
Latex allergy: ☐Yes ☐No
Patient Weight: _____ **Patient Height:** _____
Medical History -Please attach all lab/test results/treatment plans
Comorbidities: _____

Previous and Current Medication Use:

_____☐Current ☐Failed ☐Intolerant ☐Other:_____ Dates used: _____
_____☐Current ☐Failed ☐Intolerant ☐Other:_____ Dates used: _____
Expected First Dose Date: _____Injection Instruction needed: ☐Yes ☐No

Prescriber Information

Practice/ Organization Name: _____
Prescriber Name:_____
City: _____State: _____ Zip: _____
DEA#_____NPI#_____
Physician Specialty: _____

Address:_____
Phone#:_____Fax#:_____
License#:_____Medicaid UPIN#:_____

Date Shipment Needed: _____
Ship to: ☐ **Patient** ☐ **Prescriber** ☐ **Other:**_____

Shipment Address: _____Attn: _____ City: _____State: _____Zip:_____

If shipped to the prescriber's office,Prescriber accepts on behalf of patient for administration in office.

elixir
SPECIALTY PHARMACY

Growth Disorder Enrollment Form
Phone: 877-437-9012 Fax: 877-309-0687

Patient Name: _____ **Patient Date of Birth:** _____

Prescriber Name: _____ **Phone:** _____ **Date:** _____

Prescriber Address: _____

☐ **Genotropin® (somatropin [rDNA] for injection)**

☐ Cartridge (for use in PEN or MIXER Device): ☐ 5mg ☐ 12mg
☐ MiniQuick Device: ☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg

☐ **Nutropin® (somatropin [rDNA] for injection) AQ NuSpin Cartridge**
☐5mg/2ml ☐10mg/2ml ☐20mg/2ml

☐ **Humatrope® (somatropin [rDNA] for injection)**
☐ Cartridge for use in the HumatroPen®: ☐ 6mg ☐ 12mg ☐ 24mg
☐ 5mg Vials

☐ **Norditropin® (somatropin [rDNA] for injection) FlexPro® Pen Device**
☐ 5mg/1.5ml ☐ 10mg/1.5ml ☐ 15mg/1.5ml ☐ 30mg/3ml

☐ **Omnitrope® (somatropin [rDNA] for injection)**
☐ Pen Device: ☐ 5mg ☐ 10mg
☐ 5.8mg Vial

☐ **Saizen® (somatropin [rDNA] for injection)**
☐ Vial w/ bacteriostatic water for Inj 0.3%: ☐ 5mg ☐ 8.8mg
☐ 8.8mg click.easy® cartridge with Sterile Water for Inj 0.3%

☐ **Skytrofa® (Lonapegsomatropin-tcgd)**
☐ 3mg ☐ 6.3mg ☐ 7.6mg ☐ 9.1mg ☐ 11mg ☐ 13.3mg

Dose: Inject _____ mg subcutaneously _____ days per week; or
Inject _____ mg/kg subcutaneously _____ days per week

If Brand required "Dispense as Written" must be handwritten

Quantity Prescribed:_____Refills Authorized:☐0 ☐1 ☐3 ☐6 ☐11 ☐____

Prescriber Signature: *X*_____ Date: _____/_____/_____