

Deliver to:  Patient's Home  Prescriber's Office  Other: \_\_\_\_\_  Hold shipment until notified by prescriber  Anticipated Start Date: \_\_\_\_\_

### 1. Patient Information

Last Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Mobile Phone: \_\_\_\_\_  
 First Name: \_\_\_\_\_ Home Address: \_\_\_\_\_  
 S.S. #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Guardian/Caregiver: \_\_\_\_\_ Sex:  Male  Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lbs.  kg.

### 2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & medical)

Medical Insurance: \_\_\_\_\_ Phone: \_\_\_\_\_ Prescription Card: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Subscriber Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ BIN/PCN: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

### 3. Prescriber Information

Prescriber Name: \_\_\_\_\_  MD  DO  NP  PA License #: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_  
 Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_ Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Collaborating Physician: \_\_\_\_\_

### 4. Diagnosis & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: \_\_\_\_\_ Meds Tried & Failed: \_\_\_\_\_  
 Secondary ICD-10: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Concurrent Medications: \_\_\_\_\_  
 Vaccination History: \_\_\_\_\_

### 5. Prescription Information

Medication	Dose/Strength	Directions	Dispense	Refills
<input type="checkbox"/> Genotropin®	<b>Genotropin Cartridge:</b> <input type="checkbox"/> 5mg <input type="checkbox"/> 12mg <b>Genotropin MiniQuick®:</b> <input type="checkbox"/> 0.2mg <input type="checkbox"/> 0.4mg <input type="checkbox"/> 0.6mg <input type="checkbox"/> 0.8mg <input type="checkbox"/> 1.0mg <input type="checkbox"/> 1.2mg <input type="checkbox"/> 1.4mg <input type="checkbox"/> 1.6mg <input type="checkbox"/> 1.8mg <input type="checkbox"/> 2.0mg	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Humatrope® Cartridge	<input type="checkbox"/> 6mg (Gold) <input type="checkbox"/> 12mg (Purple) <input type="checkbox"/> 24mg (Teal)	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Nutropin AQ NuSpin®	<input type="checkbox"/> 5mg/2mL <input type="checkbox"/> 10mg/2mL <input type="checkbox"/> 20mg/2mL	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Norditropin FlexPro® Pen	<input type="checkbox"/> 5mg/1.5mL (Orange) <input type="checkbox"/> 10mg/1.5mL (Blue) <input type="checkbox"/> 15mg/1.5mL (Green) <input type="checkbox"/> 30mg/3mL (Purple)	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Omnitrope®	<b>Cartridge:</b> <input type="checkbox"/> 5mg/1.5mL <input type="checkbox"/> 10mg/1.5mL <b>Vial:</b> <input type="checkbox"/> 5.8mg	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Saizen®	<input type="checkbox"/> 5mg LYO <input type="checkbox"/> 8.8mg LYO <input type="checkbox"/> 8.8 mg Click.easy® Cartridge	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Somavert® PDS Kit	<input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 20mg <input type="checkbox"/> 25mg <input type="checkbox"/> 30mg	Inject _____ mg SC once daily, _____ days per week		
<input type="checkbox"/> Other:		Inject _____ mg SC once daily, _____ days per week		

**Patient Support Programs:** Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

**Account Manager**

Patient Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible \_\_\_\_\_ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Prescriber Signature-Dispense as Written \_\_\_\_\_ **PREScriBER SIGNATURE REQUIRED. NO STAMPS.** Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_