Lumicera Health Services
2601 West Beltline Hwy, Ste 302, Madison, WI 53713 / Phone: (855) 847-3553 / Fax: (855) 847-3558

Growth Hormone Enrollment Form

Ship to: ○ Patient ○ Office ○ Other Date: Needs by Date:

PATIENT INFORMATION

Patient Name _____
Address _____
Address 2 _____
City, State, ZIP _____
Preferred Phone _____ Type _____
Alternate Phone _____ Type _____
Email _____
DOB (mm/dd/yyyy) _____ Gender ○ Male ○ Female

PRESCRIBER INFORMATION

Prescriber Name _____ Specialty _____
State License # _____ UPIN _____
DEA _____ NPI _____
Group/Hospital _____
Address _____
City, State, ZIP _____
Phone _____ Fax _____
Office Contact _____ Phone _____

INSURANCE INFORMATION *(Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical)*

CLINICAL INFORMATION

Diagnosis (*Please include diagnosis name and ICD-10)*

○ Diagnosis: _____ICD-10 Code: _____
Date of Diagnosis: _____
Weight: _____ lbs/kg Height :_____in/cm
Is the patient pregnant, nursing, or planning pregnancy?: ○ Yes ○ No ○ N/A
Creatinine: _____ Date: _____
IGF-1: _____BP3: _____
Provocative Test Results:
Agent_____Date:_____
Peak Value: _____ Units: _____
Agent_____ Date:_____
Peak Value: _____Units: _____

Therapy: ○ New ○ Continuing Therapy ○ Restart
Concomitant medications: _____
_____
Allergies: _____
Has the patient been previously treated for this condition? ○ Yes ○ No
Prior failed medication (medication and duration of treatment/reason for d/c):
_____
Who will administer injection? (if applicable): _____
Patient trained on injection? (if applicable): ○ Yes ○ No
Pharmacy injection training needed? (if applicable): ○ Yes ○ No
Additional comments: _____
Please attach recent clinical notes, including growth charts/velocity.

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
○ Genotropin® (somatropin)	○ **Cartridge:** ○ 5mg ○ 12mg ○ **Mini-Quick:** ○ 0.2mg ○ 0.4mg ○ 0.6mg ○ 0.8mg ○ 1mg ○ 1.2mg ○ 1.4mg ○ 1.6mg ○ 1.8mg ○ 2mg			
○ Humatrope® (somatropin)	○ **Cartridge:** ○ 6mg ○ 12mg ○ 24mg ○ **Vial:** ○ 5mg			
○ Increlex® (mecasermin injection)	○ 40mg/4ml vial			
○ Norditropin® (somatropin)	○ **FlexPro® Pen** ○ 5mg/1.5mL ○ 10mg/1.5mL ○ 15mg/1.5mL ○ 30mg/3mL			
○ Nutropin AQ® (somatropin)	○ **NuSpin®** Pen: ○ 5mg/2ml ○ 10mg/2ml ○ 20mg/2ml			
○ Omnitrope® (somatropin)	○ 5mg/1.5ml ○ 10mg/1.5ml ○ 5.8mg/vial			
○ Saizen® (somatropin)	○ **Click Easy Cartridge:** ○ 8.8mg ○ **Vial:** ○ 5mg ○ 8.8mg			
○ Zorbtive® (somatropin)	○ 8.8mg vial			
○ Zomacton (vial) (somatropin)	○ 5mg ○10mg			
○ Pen Needles	Size: _____ Quantity: _____			
○ Syringes	Size: _____ Quantity: _____			

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: _____ _____ _____
PRODUCT SUBSTITUTION PERMITTED *Date* *DISPENSE AS WRITTEN*