

## Humana Specialty Pharmacy<sup>®</sup>

Monday – Friday: 8 a.m. – 11 p.m., Eastern time

Saturday: 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

### Human Growth Hormone Prescription Form

#### Patient information

Patient: \_\_\_\_\_  Female  Male DOB: \_\_\_\_\_ Insurance plan: \_\_\_\_\_ Plan ID #: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Home phone #: \_\_\_\_\_ Cell phone #: \_\_\_\_\_ Caregiver: \_\_\_\_\_ Caregiver phone #: \_\_\_\_\_  
 Other medical conditions: \_\_\_\_\_ Allergies:  No  Yes: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_  lb  kg Date: \_\_\_\_\_

#### Clinical information

ICD-10 code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  New therapy  Continuing therapy  Investigational therapy  
 Previous therapies, discontinuation reasons and dates:  
 Therapy: \_\_\_\_\_ Discontinuation reason: \_\_\_\_\_ Dates: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please provide the complete history and latest physical documentation, including the patient evaluation, screening, diagnostic testing, growth charts, etc.

#### Prescription information

**Note:** Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose form and strength	Directions	Quantity	Refills
<input type="checkbox"/> Genotropin <input type="checkbox"/> The patient is using the Genotropin Mixer device from Pfizer.	<input type="checkbox"/> Cartridge <input type="checkbox"/> 5 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> MiniQuick <input type="checkbox"/> _____	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Humatrope <input type="checkbox"/> Send corresponding pen device.	<input type="checkbox"/> Cartridge <input type="checkbox"/> 6 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> 24 mg <input type="checkbox"/> Vial <input type="checkbox"/> 5 mg	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Norditropin	FlexPro <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Nutropin AQ	NuSpin pen <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Omnitrope	<input type="checkbox"/> Cartridge <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> Vial <input type="checkbox"/> 5.8 mg	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Saizen* *All administration devices and pen needles must be supplied by EMD Serono.	<input type="checkbox"/> Saizenprep cartridge <input type="checkbox"/> 8.8 mg <input type="checkbox"/> Vial <input type="checkbox"/> 5 mg and diluent amount _____ <input type="checkbox"/> 8.8 mg and diluent amount _____	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> Zomacton	Vial <input type="checkbox"/> 5 mg and diluent amount _____ <input type="checkbox"/> 10 mg <input type="checkbox"/> 10 mg with vial adapter	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____
<input type="checkbox"/> _____	_____	_____	<input type="checkbox"/> 1 month <input type="checkbox"/> _____	<input type="checkbox"/> 1 year <input type="checkbox"/> _____

#### Prescriber and shipping information (please print)

Prescriber: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Ship to:  Patient  Office  Other: \_\_\_\_\_ Office phone number: \_\_\_\_\_ Office fax number: \_\_\_\_\_  
 Office address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

We will dispense this prescription as generic, unless the prescriber indicates "Dispense as Written" here: \_\_\_\_\_  
 The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language.  
 Noncompliance with state-specific requirements could result in outreach to the prescriber.