Fax: 877-405-7940
Phone: 800-486-2668

CenterWell Specialty Pharmacy

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Monday – Friday: 8 a.m. – 11 p.m., and
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
❒ Genotropin ❒ The patient is using the Genotropin Mixer device from Pfizer.	❒ Cartridge ❒ 5 mg ❒ 12 mg ❒ MiniQuick ❒ __________	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Humatrope ❒ Send corresponding pen device.	❒ Cartridge ❒ 6 mg ❒ 12 mg ❒ 24 mg ❒ Vial ❒ 5 mg	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Norditropin	FlexPro ❒ 5 mg ❒ 10 mg ❒ 15 mg ❒ 30 mg	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Nutropin AQ	NuSpin pen ❒ 5 mg ❒ 10 mg ❒ 20 mg	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Omnitrope	❒ Cartridge ❒ 5 mg ❒ 10 mg ❒ Vial ❒ 5.8 mg	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Saizen* *All administration devices and pen needles must be supplied by EMD Serono.	❒ Saizenprep cartridge ❒ 8.8 mg ❒ Vial ❒ 5 mg and diluent amount _____ ❒ 8.8 mg and diluent amount ___	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Skytrofa *Skytrofa Auto-injector must be supplied by Ascendis Pharm Customer Support	❒ 3mg ❒ 7.6mg ❒ 3.6mg ❒ 9.1mg ❒ 4.3mg ❒ 11mg ❒ 5.2mg ❒ 13.3mg ❒ 6.3mg	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____
❒ Zomacton	Vial ❒ 5 mg and diluent amount ______ ❒ 10 mg ❒ 10 mg with vial adapter	____________ ____________	❒ 1 month ❒ ______	❒ 1 year ❒ _____

Prescriber and shipping information (please print)

Prescriber: ________________________ NPI: ____________DEA:____________
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.