Giant Eagle Specialty Pharmacy

Phone: 1-844-259-1891
Fax: 1-877-645-4142

To ePrescribe send prescription to:
Giant Eagle Pharmacy (#8991)
2500 Lovi Road
Freedom, PA 15042

GROWTH HORMONE THERAPY ENROLLMENT FORM

Today's Date: _____

Ship to: ☐ Patient ☐ Physician ☐ Store for Patient Pick-up **Date Shipment Needed:**_____ **Rx:** ☐ New ☐ Refill **RN Instruction Needed:** ☐ Yes ☐ No
All supplies, including syringes and needles, will be dispensed if needed.

Patient Information

Date: _____ ☐ Male ☐ Female DOB: _____
Patient's First Name: _____ Patient's Last Name: _____
Address: _____ City: _____ State: _____ ZIP: _____
Best Phone Number: _____ Alternate Phone Number: _____
Caregiver: _____ Allergies: _____
Store Preference (address): _____
Patient has a negative TB test result. Date of test:_____
Emergency Contact Name:_____ Emergency Contact Phone #: _____

Insurance Information: Please fax copy of insurance card (front + back)

Diagnosis Medical History

DIAGNOSIS / ICD 10 CODE _____**:** Date of Diagnosis: _____

☐ Panhypopituitarism ☐ Pubertal Dosing ☐ Prader-Willi Syndrome ☐ Idiopathic Short Stature (ISS)
☐ GHD - Adult ☐ Small Gestational Age ☐ Noonan's Syndrome ☐ Primary IGF-1 Deficiency
☐ GHD - Pediatric ☐ Chronic Renal Insufficiency (CRI) ☐ Turner Syndrome
☐ Other (Please indicate ICD-10 code & description): _____

Visit Date: _____ Next Clinic Visit: _____ Has patient previously been on growth hormone? ☐ Yes ☐ No
If yes, start date and product: _____

Prescription

MEDICATIONS	DOSE/STRENGTH	DIRECTIONS	QTY	REFILLS
☐ Genotropin®	Intra-Mix® cartridges: ☐ 1.5 ☐ 5.8 Pen Cartridges: ☐ 5 ☐ 12 MiniQuick®: _____mg			
☐ Genotropin® Pen	Size: ☐ 5 ☐ 12			
☐ Genotropin® Mixer Device	N/A			
☐ Humatrope®	Cartridge kits: ☐ 6mg ☐ 12mg ☐ 24mg Vial kit: ☐ 5mg			
☐ HumatroPen®	HumatroPen®: ☐ 6mg ☐ 12mg ☐ 24mg			
☐ Norditropin®				
☐ FlexPro	☐ 5mg ☐ 10mg ☐ 15mg			
☐ Nordiflex® Prefilled Pens	☐ 30mg			
☐ Omnitrope®	☐ 5.8mg/vial ☐ 5mg/1.5ml cartridges ☐ 10mg/1.5ml cartridges			
☐ Omnitrope Pen®	Size: ☐ 5 ☐ 10			
☐ Saizen®	click.easy cartridge: ☐ 8.8mg vial kits: ☐ 5mg ☐ 8.8mg			
☐ cool.click™ 2 device	N/A			
☐ cool.click™ device	N/A			
☐ easypod™	N/A			
☐ one-click™ device	N/A			
☐ Tev-Tropin®	5mg vial			
☐ Tjet Injector System				
☐ Other				

Prescriber Information

Date Prescription Needed: _____
Physician Name (please print): _____ Contact Name: _____
Phone #: _____ Fax #: _____ NPI #: _____
Office Address: _____ City: _____ State: _____ ZIP: _____
State License #: _____ DEA #: _____

In order for a brand name to be dispensed, the prescriber must hand write "brand medically necessary" or "brand necessary" in the space below:
_____

I authorize this prescription and for Giant Eagle Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

Physician Signature: _____ **Date:** _____