ASP CARES
Growth Hormone
Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange

Ship To : ☐ Patient Home ☐ MD Office

MAIN POINT OF CONTACT
Name:_____
Phone:_____

PATIENT INFORMATION (Use this area or attach patient demographics)
Name:_____ Phone:_____ Phone 2:_____
Home Address:_____ City:_____ State:_____ Zip Code:_____
DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.
Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))
Primary Insurance:_____ Secondary Insurance:_____
ID#:_____ RxBin:_____ ID#:_____ RxBin:_____
RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)
Primary Diagnosis:_____ ICD10 Code:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	QTY	REFILLS
☐ **Genotropin Pen** (two-chamber cartridge) ☐ 5 mg/mL (Green Pen)* ☐ 12mg/mL (Purple Pen)* Genotropin Miniquick ☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg *Sig:_____* *Diluent contains: M-Cresol preservative & phosphate buffer + Diluent contains: Posphate buffer with no preservative		
☐ **Humatrope powder with diluent:** ☐ 5mg/5mL vial ☐ 6mg cartridge (gold) ☐ 12 mg cartridge (teal) ☐ 24 mg cartridge (purple) *Sig:_____*		
☐ **Increlex 40mg/4mL** *Sig:_____* (Note: maximum dose of 0.12 mg/kg SQ twice dialy, injection should be administered shortly (20 min) before or after a meal or snack.) Diluent contains benzyl alcohol		
☐ **Lupron Depot-Ped** ☐ 7.5mg ☐ 11.25mg ☐ 11.25mg* ☐ 15mg ☐ 30mg *Sig:_____*		
☐ **Norditropin FlexPro** ☐ 5mg/1.5mL (orange) ☐ 10mg/1.5mL (blue) ☐ 15mg/1.5mL (green) ☐ 30mg/3mL (purple) *Sig:_____*		
☐ **NuSpin** ☐ 5mg/2mL (clear) ☐ 10mg/2mL (green) ☐ 20mg/2mL (blue) **Nutropin AQ Pen Cartridge** ☐ 10mg/2mL (yellow) ☐ 20mg/2mL (purple) *Sig:_____* Diluent contains phenol preservative and sodium citrat buffer		
☐ **Omnitrope** ☐ 5mg/1.5mL cartridge for Pen 5 (dark blue) ☐ 10mg/1.5mL for Pen 10 (light blue) powder with diluent ☐ 5.8mg/vial *Sig:_____*		
☐ **Saizen powder with diluent** ☐ 5mg/vial* ☐ 8.8mg/vial* ☐ Click easy Cartridge 8.8mg *Sig:_____* *Diluent contains: M-Cresol preservative*		
☐ **Zomacton powder with diluent** ☐ 5mg/vial (Benzyl alcohol preservative) ☐ 10mg/vial (0.33% metacresol preservative) *Sig:_____*		
☐ **Zorbtive powder with diluent** 8.8 mg/vial (Note: max dose of 8mg/day; max duration of 4 weeks) *Sig:_____*		
☐ **Other/Supplies:**		

Prescriber Name:_____ NPI#:_____
Address:_____ City:_____ State:_____ Zip Code:_____
Phone:_____ Fax:_____

*Prescriber Signature:_____ Date:_____

Please fax completed form to 1 (888) 294-9434