



Orsini

Specialty Pharmacy
Services

Fax: 877.370.7048 Phone: 800.253.5915

OMNITROPE® PATIENT ENROLLMENT

1 PATIENT INFORMATION

(Please complete the following information)

Patient Name: _____

DOB: _____ Gender: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact: _____

Phone: _____ Please attach demographic information

2 INSURANCE

Please attach front and back of patient's insurance card, prescription benefit card, and/or Medicaid card.

Primary Insurance: _____

ID: _____ Group: _____

Secondary Insurance: _____

ID: _____ Group: _____

3 PATIENT DIAGNOSIS

PEDIATRIC:

Please select
all that apply:

- Growth Hormone Deficiency (E23.0)
- Prader-Willi Syndrome (Q87.11)
- Small for gestational age (P05.10)
- Turner's Syndrome (Q96.9)
- Idiopathic Short Stature (R62.52)

ADULT:

Adult onset growth hormone deficiency (E23.0)

Adult growth hormone deficiency with onset in childhood (E23.0)

4 MEDICAL ASSESSMENT

Current Height (in cm): _____

Current Weight (in kg): _____

Allergies: _____

Current Medication list: _____

5 PRESCRIPTION INFORMATION

DRUG:

Omnitrope PEN 5mg/1.5ml

Omnitrope PEN 10mg/1.5ml

DOSE:

_____ mg/injection _____ days per week
QS 30-Day QS 90-Day REFILL X _____

SUPPLIES:

Pen Needle for Injection:

31G; 8MM Pen Needle

31G; 5MM Pen Needle

Qty: 100 REFILL x _____

Additional Supplies:

- Sharps Container
- Alcohol Swabs
- Device (if first fill ONLY)

6 PRESCRIBER INFORMATION

Prescriber Name: _____

NPI: _____ DEA: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____

Phone: _____ Fax: _____

7 PHYSICIAN AUTHORIZATION

Physician's Signature

Date of Signature

May Substitute

May NOT Substitute

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