



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: \_\_\_\_\_  
(if applicable)  
Secondary Insurance: \_\_\_\_\_ ID: \_\_\_\_\_ Group: \_\_\_\_\_  
(if applicable)

### 3 PATIENT DIAGNOSIS

Please select  
all that apply:

#### PEDIATRIC:

- ☐ 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

May Substitute

May NOT Substitute

Physician's Signature \_\_\_\_\_

Date of Signature \_\_\_\_\_

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