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 _____