ameripharma SPECIALTY CARE

Growth Hormone Deficiency

HGH Prescription Refill Form

Phone: 877-778-0318 Fax: 877-778-0399

Patient Information

Patient Name: _____ ☐ Male ☐ Female DOB: _____ SS#: _____

Address: _____

Primary Phone #: _____ ☐ Cell Alternate Phone #: _____ ☐ Cell

Caregiver: _____ Height: _____ Weight: _____ ☐ lbs ☐ kg Date: _____

Allergies: _____ ☐ No Known Drug Allergies

Prescription Information

Medication	Dose / Strength	
☐ Genotropin®	☐ cartridge:	☐ 5mg ☐ 12mg
	☐ mini-quick:	☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg
☐ Humatrope®	☐ cartridge:	☐ 6mg ☐ 12mg ☐ 24mg
	☐ vial:	☐ 5mg
☐ Norditropin®	☐ FlexPro®:	☐ 5mg ☐ 10mg ☐ 15mg
	☐ Nordiflex®:	☐ 30mg/3mL
☐ Nutropin® AQ	☐ NuSpin® Pen:	☐ 5mg ☐ 10mg ☐ 20mg
	☐ cartridge:	☐ 10mg ☐ 20mg
☐ Omnitrope®	☐ cartridge:	☐ 5mg ☐ 10mg
	☐ vial:	☐ 5.8mg
☐ Saizen®	☐ vial:	☐ 5mg
	☐ vial:	☐ 8.8mg
	☐ easy click cartridge:	☐ 8.8mg
☐ Pen Needles	size _____ quantity _____	
☐ Syringes	size _____ quantity _____	
sig	**diluent amount:** _____ **dispense:** _____ **months supply** **injection volume:** _____ **refill:** _____ **times or through** _____ *date* **dose:** _____ **mg** _____ **days per week**	

Prescriber + Shipping Information

Prescriber (Print Full Name): _____ Office Contact: _____

Preferred Method of Contact: ☐ phone ☐ fax ☐ email Preferred Contact Person's Email: _____

Ship to: ☐ patient ☐ office ☐ alternate Address: _____

Office Address: _____

Phone: _____ Fax: _____ NPI: _____ DEA: _____

Prescriber's Signature: _____ Date: _____

I authorize Ameripharma and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

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