



Growth Hormone Enrollment Form

Phone: (267) 402-1711

FAX to (215) 761-9165

Please fill out all requested information completely and attach growth chart:

Patient Name:	Home Phone #:
Shipping Address:	City, State, Zip:
Sex: <input type="checkbox"/> M or <input type="checkbox"/> F	Date of Birth:
Member ID #:	Carrier:
Allergies:	Special Instructions (Non-English speaking patient, etc):

Physician's Name:	Hospital/Clinic:
Address:	City, State, Zip:
Phone #: Fax #:	Office Contact:

Primary Diagnosis: <input type="checkbox"/> 253.3 Isolated Deficiency of Human GH/ Somatotropin Deficiency Syndrome <input type="checkbox"/> 253.7 Iatrogenic Pituitary Disorder <input type="checkbox"/> 253.2 Panhypopituitarism	<input type="checkbox"/> 585 Chronic Renal Failure/Insufficiency <input type="checkbox"/> 758.6 Gonadal Dysgenesis (Turner Syndrome) <input type="checkbox"/> 759.81 Prader-Willi Syndrome <input type="checkbox"/> 783.4 Short Stature	<input type="checkbox"/> Other (please indicate ICD-9 code & description) <hr/> <hr/>
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Last Office Visit:	Height:	Weight:	
IGF-1:	IGF-BP3:	Father's Height:	Mother's Height:
Bone Age:	Chronological Age:	Date of Test:	
Provocative Testing Agent:	Response:	Date of Test:	
Provocative Testing Agent:	Response:	Date of Test:	
Pertinent History:			
Previous GH Therapy? <input type="checkbox"/> N <input type="checkbox"/> Y Start Date and Product:			
Office Notes:			

<input type="checkbox"/> Nutropin [®] AQ, 10mg vial <input type="checkbox"/> 5mg vial <input type="checkbox"/> 10mg vial	<input type="checkbox"/> Humatrope [®] , 5mg vial <input type="checkbox"/> HumatroPEN [®] <input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg	Genotropin [®] <input type="checkbox"/> Pen Device or <input type="checkbox"/> Mixer <input type="checkbox"/> 1.5mg <input type="checkbox"/> 5.8mg <input type="checkbox"/> 13.8mg <input type="checkbox"/> Genotropin [®] Miniquick mg	Norditropin [®] <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg <input type="checkbox"/> 15mg/1.5ml Saizen [®] <input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg Geref [®] <input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg Other:
Quantity: _____		Refill x _____ months	Next Office Visit: _____
Instructions: _____			
Physician's Signature: _____		DEA #: _____	

For Internal Use Only: INFO Doc #: Date Rec'd: Cov: <input type="checkbox"/> Y <input type="checkbox"/> N Med Rx
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Provider Communications

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield. Independent licensees of the Blue Cross and Blue Shield Association.