AmeriHealth

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: ☐M or ☐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: **☐ 253.3 Isolated Deficiency of Human GH/ Somatropin Deficiency Syndrome** **☐ 253.7 Iatrogenic Pituitary Disorder** **☐ 253.2 Panhypopituitarism**	**☐ 585 Chronic Renal Failure/Insufficiency** **☐ 758.6 Gonadal Dysgenesis (Turner Syndrome)** **☐ 759.81 Prader-Willi Syndrome** **☐ 783.4 Short Stature**	**☐ Other (please indicate ICD-9 code & description)** **_____** **_____**

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? ☐N ☐Y Start Date and Product:			
Office Notes:			

☐ Nutropin® AQ, 10mg vial **Nutropin®** **☐5mg vial ☐10mg vial**	**☐ Humatrope®, 5mg vial** **☐ HumatroPEN®** **☐ 6mg ☐12mg ☐24mg**	**Genotropin®** **☐Pen Device or ☐Mixer** **☐1.5mg ☐5.8mg** **☐13.8mg** **☐Genotropin® Miniquick _____mg**	**Norditropin® ☐4mg ☐8mg ☐15mg/1.5ml** **Saizen® ☐5mg ☐8.8mg** **Geref® ☐0.5mg ☐1mg** **Other:** **_____**

Quantity: _____ **Refill x _____months** **Next Office Visit: _____**

Instructions: _____

Physician's Signature: _____ **DEA #: _____**

For Internal Use Only:

INFO Doc #:	**Date Rec'd:**	**Cov: ☐Y ☐N**	**Med**	**Rx**

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