

# HGH prescription refill

**patient information**

patient: \_\_\_\_\_ male  
last name, first name female DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

address: \_\_\_\_\_  
street city state zip

primary phone number: \_\_\_\_\_ cell alternate phone number: \_\_\_\_\_ cell

caregiver: \_\_\_\_\_ height: \_\_\_\_\_ weight: \_\_\_\_\_ lbs kg date: \_\_\_\_\_

allergies: \_\_\_\_\_ NKDA

**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
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:	8.8 mg		
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): \_\_\_\_\_ office contact: \_\_\_\_\_

preferred method of contact: phone fax email preferred contact persons email: \_\_\_\_\_

ship to: patient office alternate \_\_\_\_\_  
(street, suite, city, state, zip)

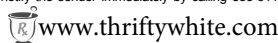
office address: \_\_\_\_\_  
(street, suite, city, state, zip)

phone: \_\_\_\_\_ fax: \_\_\_\_\_ NPI: \_\_\_\_\_ DEA: \_\_\_\_\_

prescriber's signature: \_\_\_\_\_ date: \_\_\_\_\_  
I authorize Thrifty White Pharmacy 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)**

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