



Phone: 800-818-6486 ♦ Fax: 800-818-6490

Fax Prescription Form

Please complete the prescription on the following page or attached SMN and return by fax to PSI, along with this completed cover sheet. PSI's fax number is **800-818-6490**.

PSI will promptly contact the person listed below with coverage criteria and patient status.

Office Contact: _____

Preferred Method of Contact: ☐ Phone: _____ ☐ Fax: _____ ☐ E-mail: _____

Patient's Name: _____ DOB: _____

Prescription Form – Growth Hormone

Patient: _____ DOB: _____ DX: _____

Address: _____ Height: _____ Weight: _____

Preferred Product

- ☐ Norditropin FlexPro® 15mg (dose in 0.1mg increments; Max dose 8.0mg) _____mg SQ _____days/week
☐ Norditropin FlexPro® 10mg (dose in 0.05mg increments; Max dose 4.0mg)
☐ Norditropin FlexPro® 5mg (dose in 0.025mg increments; Max dose 2.0mg)
☐ Norditropin FlexPro® 30mg (dose in 0.1 mg increments; Max dose 8.0mg)

- ☐ Saizen® vials ☐ 8.8mg ☐ 5mg Add _____mL and inject _____mL (____mg) SQ _____days/week
Use with: ☐ cool.click™2 ☐ Insulin Syringes
☐ Saizen® click.easy® 8.8mg for one.click® device (0.12mg per click) Administer _____mg (____clicks) SQ _____days/week
☐ easypod® using Saizen® 8.8mg Cartridges (Min dose 0.15mg/Max 4.6mg) Administer _____mg SQ _____days/week
Dose adjustment (check one): ☐ Off ☐ Greater than 50% -OR- Automatic dose adjustment: ☐ 10% ☐ 25% ☐ 50%

- ☐ Humatrope® 24mg/3cc cartridges (dose in 0.1 mg increments; Max dose 6.0 mg) _____mg SQ _____days/week
☐ Humatrope® 12mg/3cc cartridges (dose in 0.05 mg increments; Max dose 3.0 mg)
☐ Humatrope® 6mg/3cc cartridges (dose in 0.025mg increments; Max dose 1.5 mg)
☐ Humatrope® 5mg powder vials Add _____mL and inject _____mL (____mg) SQ _____days/week

- ☐ Genotropin 12mg cartridges (dose in 0.2mg increments; Max dose 4.0mg) _____mg SQ _____days/week
☐ Genotropin 5mg cartridges (dose in 0.1mg increments; Max dose 2.0mg)
☐ PEN® 5 ☐ PEN® 12 ☐ MIXER® & Insulin Syringes
☐ Genotropin MINIUICK® Syringes (dose in 0.2mg increments; Preservative Free)
☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg

- ☐ Omnitrope® 10mg Cartridges (dose in 0.1mg increments) _____mg SQ _____days/week
☐ Omnitrope® 5mg Cartridges (dose in 0.05mg increments)
☐ Omnitrope® 5.8mg Vials Add _____mL and inject _____mL (____mg) SQ _____days/week

- ☐ Other: _____
Administer: _____
☐ Other: _____
Administer: _____

Dispense above RX with all necessary supplies for administration: Pen Needle Size (check one) ☐ 29 ☐ 30 ☐ 31 ☐ 32

Disp _____ **month(s) supply** **Refills:** _____ **Prn x 1 year** **or** _____ **months total**

Provider Name: _____ NPI: _____ DEA: _____ License #: _____

Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____