



HGH/TURNER'S/PRADER WILLI/IDOPATHIC REFERRAL

PATIENT INFORMATION		PHYSICIAN INFORMATION	
PATIENT NAME:		PHYSICIAN NAME:	
DOB:	SEX: <input type="checkbox"/> M <input type="checkbox"/> F	LIC#	NPI:
ADDRESS:		ADDRESS:	
CITY/STATE/ZIP		CITY/STATE/ZIP:	
PHONE:		PHONE	FAX:
ALT PHONE:		OFFICE CONTACT :	EXT:

INSURANCE INFORMATION:	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
SUBSCRIBER:	SUBSCRIBER:
ID#:	ID#:
GROUP POLICY:	GROUP POLICY:
PHONE:	PHONE:
EMPLOYER:	EMPLOYER:

PRESCRIPTION:	DOSE/DIRECTIONS:
GENOTROPIN® (SOMATROPIN DNA ORIGIN)	_____ MG CARTRIDGE SIG: _____ REFILL
HUMATROPE® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 5-MG POWDER VIAL WITH DILUENT <input type="checkbox"/> 6MG CARTRIDGE <input type="checkbox"/> 12 MG CARTRIDGE <input type="checkbox"/> 24 MG CARTRIDGE QUANTITY _____ SIG: _____ Q _____ WEEKS _____ REFILLS
NORDITROPIN® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 5MG/ 1.5ML PEN <input type="checkbox"/> 15 5MG/ 1.5ML PEN <input type="checkbox"/> 10 5MG/ 1.5ML PEN <input type="checkbox"/> 30MG/3ML QUANTITY _____ SIG: _____ Q _____ WEEKS _____ REFILLS
OMINITROPE® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 5.8 MG POWDER VIAL <input type="checkbox"/> 5MG CARTRIDGE <input type="checkbox"/> 10 MG CARTRIDGE SIG: _____ Q _____ REFILLS
SAIZEN® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 5MG POWDER VIAL WITH DILUENT <input type="checkbox"/> 8.8 MG POWDER VIAL WITH DILUENT <input type="checkbox"/> 8.8 MG CARTRIDGE SIG: _____ Q _____ REFILLS
SEROSTIM® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 4MG POWDER VIAL WITH 1ML DILUENT <input type="checkbox"/> 5 MG POWDER VIAL WITH 1ML DILUENT <input type="checkbox"/> 6 MG POWDER VIAL WITH 1ML DILUENT SIG: _____ Q _____ REFILLS
TEV-TROPIN® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 5MG POWDER VIAL WITH DILUENT SIG: _____ Q _____ MONTHS _____ REFILLS
ZORBTIVE® (SOMATROPIN DNA ORIGIN)	<input type="checkbox"/> 8.8 MG POWDER VIAL WITH DILUENT SIG: _____ Q _____ MONTHS _____ REFILLS
(WRITE IN ADDITIONAL RX)	

DIAGNOSIS/STATEMENT OF MEDICAL NECESSITY: (PLEASE INCLUDE ALL RELEVANT DOCUMENTATION WHEN FAXING)

SIGNATURE: _____

DATE: _____

FAX TO 949-582-6111