CenterWell Specialty Pharmacy

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CenterWell Specialty Pharmacy®

Monday – Friday, 8 a.m. – 11 p.m.,
and Saturday, 8 a.m. – 6:30 p.m., Eastern time

Remove above portion before faxing. Please complete the prescription form in its entirety and fax with secure cover sheet to the number above.

Human Growth Hormone Prescription Form

Patient information

Patient: _____ ❒ Female ❒ Male DOB: _____ Insurance plan: _____ Plan ID #: _____
Address: _____ City: _____ State: _____ ZIP code: _____
Home phone #: _____ Cell phone #: _____ Caregiver: _____ Caregiver phone #: _____
Other medical conditions: _____ Allergies: ❒ No ❒ Yes: _____
Height: _____ Weight: _____ ❒ lbs ❒ kg Date: _____

Clinical information

ICD-10 code: _____ Date of diagnosis: _____ ❒ New therapy ❒ Continuing therapy ❒ Investigational therapy
Previous therapies, discontinuation reasons and dates:

Therapy:	Discontinuation reason:	Dates:
_____	_____	_____
_____	_____	_____

Please provide the complete history and latest physical documentation, including the patient evaluation, screening, diagnostic testing, growth charts, etc.

Prescription information

Note: Ohio law allows one prescription per preprinted order form. Please use additional forms for more than one prescription.

Medication	Dose form and strength	Directions	Quantity	Refills
❒ Genotropin	❒ 5 mg Cartridge ❒ 12 mg Cartridge ❒ MiniQuick: _____		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Humatrope ❒ Send corresponding pen device.	❒ Cartridge ❒ 6 mg ❒ 12 mg ❒ 24 mg ❒ Vial 5 mg		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Ngenla Pen	❒ 24 mg/1.2 mL ❒ 60 mg/1.2 mL		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Norditropin FlexPro	❒ 5 mg ❒ 10 mg ❒ 15 mg ❒ 30 mg		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Nutropin AQ NuSpin Pen	❒ 5 mg ❒ 10 mg ❒ 20 mg		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Omnitrope	❒ Cartridge ❒ 5 mg ❒ 10 mg ❒ Vial 5.8 mg		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Skytrofa Cartridge * Skytrofa Auto-injector must be supplied by Ascendis Pharma Customer Support	❒ 3 mg ❒ 7.6 mg ❒ 3.6 mg ❒ 9.1 mg ❒ 4.3 mg ❒ 11 mg ❒ 5.2 mg ❒ 13.3 mg ❒ 6.3 mg		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Sogroya Pen	❒ 5 mg/1.5 mL ❒ 10 mg/1.5 mL ❒ 15 mg/1.5 mL		❒ 1 month ❒ _____	❒ 1 year ❒ _____
❒ Zomacton Vial	❒ 5 mg and diluent amount _____ ❒ 10 mg ❒ 10 mg with vial adapter		❒ 1 month ❒ _____	❒ 1 year ❒ _____

Prescriber and shipping information (please print)

Prescriber: _____ NPI: _____DEA:_____
Ship to: ❒ Patient ❒ Office ❒ Other:_____ Office phone number: _____ Office fax number: _____
Office address: _____ City: _____ State: _____ ZIP code: _____
Signature: _____ Date: _____
We will dispense this prescription as generic unless the prescriber indicates "Dispense as Written" here: _____
The prescriber is to comply with his/her state-specific prescription requirements, such as e-prescribing, state-specific prescription form and fax language. Noncompliance with state-specific requirements could result in outreach to the prescriber.