benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: ____________
☐ NEW PATIENT ☐ CURRENT PATIENT

HUMAN GROWTH HORMONE REFERRAL

PATIENT INFORMATION

Patient Name ____________
Address ____________
City ____________ State ________ Zip ________
Home Phone ____________ Cell ____________
DOB ____________ SSN ____________
Drug Allergies ____________ ☐ Male ☐ Female
Patient Weight: ____________ Height: ____________

PRESCRIBER INFORMATION

Prescriber Name ____________ DEA# ____________
NPI# ____________ Tax ID ____________
Practice Name ____________
Address ____________ Suite ________
City ____________ State ________ Zip ________
Office Phone ____________ Fax ____________
Office Contact ____________

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance ____________
Policy # ____________ Group ____________
Insurance Phone ____________
Prescription Drug Coverage: Company ____________
RXGRP# ____________ RXBIN# ____________

Secondary Insurance (if applicable) ____________
Policy # ____________
Insurance Phone ____________
Phone ____________
PCN/ID# *(if available)* ____________

CLINICAL INFORMATION

Primary Diagnosis: ____________ ICD-10: ____________

Secondary Endocrine Diagnosis/Treatment: ____________

Has patient previously been on growth hormone? ☐ Yes ☐ No If yes, start date and product/dose: ____________

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QTY	REFILLS
☐ Genotropin®	Pen: ☐ 5mg ☐ 12mg Mini-Quick: ☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg	Inject ________mg subcutaneously daily		
☐ Humatrope®	Pen: ☐ 6mg ☐ 12mg ☐ 24mg Pre-Filled Syringe: ☐ 6mg ☐ 12mg ☐ 24mg Vial: ☐ 5mg	Inject ________mg subcutaneously daily		
☐ Increlex®	400mg vial	Inject ________mg subcutaneously daily shortly before or after a meal or snack (+/- 20 minutes).		
☐ Norditropin®	FlexPro®: ☐ 5mg ☐ 10mg ☐ 15mg Pre-filled Pen: ☐ 30mg/3ml	Inject ________mg subcutaneously daily		
☐ Nutropin®	10mg vial	Inject ________mg subcutaneously daily		
☐ Nutropin AQ®	NuSpin®: ☐ 5mg ☐ 10mg ☐ 20mg Pen: ☐ 5mg ☐ 10mg ☐ 20mg Vial: ☐ 10mg	Inject ________mg subcutaneously daily		
☐ Omnitrope®	Pen: ☐ 5mg ☐ 10mg Vial: ☐ 5.8ml	Inject ________mg subcutaneously daily		
☐ Saizen®	☐ 8.8mg Click Easy Device Vial: ☐ 5mg ☐ 8.8mg	Sig:		
☐ Tev-Tropin®	☐ 5mg Vial (Tjet Needle Free Device) ☐ 10mg	Sig:		
☐ Zorbtive®	8.8mg Vial	Inject ________mg subcutaneously daily		
☐ Lupron Depot-PED®	☐ 7.5mg ☐ 11.25mg ☐ 15mg ☐ 30mg	Sig:		

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

By signing this form and utilizing our services, you are authorizing Benevere and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (signature required. NO STAMPS) ____________ Date ____________

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