HGH

Rx International Pharmacy

Phone: (305) 221-1421
Fax: (305) 221-3275

Patient information

patient: _____ ☐ male ☐ female DOB: _____ SS#: _____
(last name, first name)

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
		☐ 2mg		
☐ **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 _____			

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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 Rx International 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)