



Patient information

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

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
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 _____		
sig	diluent amount: _____	dispense: _____ months supply		
	injection volume: _____	refill: _____ times or through _____ <small>date</small>		
	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)

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