Zarina Pharmacy
SPECIALTY & INFUSION

Growth Hormone

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐Patient ☐Office ☐Other _____ Fax Copy: ☐Rx Card Front/Back ☐Clinical Notes ☐Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐Female ☐Male

Prescriber Information

Prescriber Name		
Address		
City State Zip		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis	ICD-10

Diagnosis confirmed with appropriate lab testing and available upon request if insurance requires it.

☐Epiphysis Open: ☐No ☐Yes	Bone Age	Growth Velocity
Weight ☐kg ☐lbs	Height ☐ft ☐in	Stim #1: _____ / _____ / _____ ☐Pass ☐Fail Stim #2: _____ / _____ / _____ ☐Pass ☐Fail
Drug Allergies		Status: ☐New ☐Restart ☐Continuing

Med	Dose/Strength	Sig	Qty	Refills
☐Genotropin®	☐Cartridge: ☐5mg ☐12mg ☐Mini-quick®: ☐0.2mg ☐0.4mg ☐0.6mg ☐0.8mg ☐1mg ☐1.2mg ☐1.4mg ☐1.6mg ☐1.8mg ☐2mg		1 Month	_____
☐Humatrope®	☐Cartridge: ☐6mg ☐12mg ☐24mg ☐Vial: ☐5mg Dilute vial with _____ mL/diluent		1 Month	_____
☐Lupron Depot-Ped (4 week supply)	Syringe: ☐7.5mg (weight: 25kg or less) ☐11.25mg (weight: >25-37.5kg) ☐15mg (weight: >37.5kg)		☐1 Kit	_____
☐Lupron Depot-Ped (12 week supply)	Syringe: ☐11.25mg ☐30mg		☐1 Kit	_____
☐Ngenla™	Prefilled Pen: ☐24mg ☐60mg		1 Month	_____
☐Norditropin®	FlexPro®: ☐5mg ☐10mg ☐15mg ☐30mg		1 Month	_____
☐Nutropin® AQ	NuSpin® Pen: ☐5mg ☐10mg ☐20mg		1 Month	_____
☐Omnitrope®	☐Cartridge: ☐5mg ☐10mg ☐Vial: 5.8mg		1 Month	_____
☐Skytrofa®	Cartridge: ☐3mg ☐3.6mg ☐4.3mg ☐5.2mg ☐6.3 mg ☐7.6mg ☐9.1mg ☐11mg ☐13.3mg		1 Month	_____
☐Sogroya®	Pen: ☐5mg ☐10mg ☐15mg		1 Month	_____
☐Supprelin LA®	Implant: 50mg		12 Month	_____
Zomacton®	Vial: ☐5mg ☐10mg Dilute vial with _____ mL/diluent		1 Month	_____
☐ Other				

Supplies	Qty	Size
☐ Pen Needles		
☐ Syringes		

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Prescriber's Signature (no stamps) **Substitution Permitted** **Date**

Prescriber's Signature (no stamps) **Dispense As Written** **Date**