

**CONVERSION® ENROLLMENT FORM
TEV-TROPIN® [somatropin (rDNA origin) for injection]**

**Phone: 1-800-514-0083 Option #2
Fax to: 1-866-374-1579**

Patient/Parent/ Guardian	Patient Name:	DOB:	<input type="checkbox"/> M <input type="checkbox"/> F	
	Patient Address:	City:	ST:	ZIP:
	Parent/Guardian Name:	Home Phone #:	Work Phone #:	
	Email Address:	Cell Phone #:		
Okay to contact Parent/Guardian by phone or email <input type="checkbox"/> Yes <input type="checkbox"/> No				
Provider/ Physician	Name:	Hospital or Clinic/Contact Name/Phone and Ext. #:		
	Address:	City:	ST:	ZIP:
	Phone #:	Fax:	NPI #:	DEA #:

Physician signature REQUIRED to order TEV-TROPIN®, Tjet™, and Home-Based Injection Training.

Prescription	<input type="checkbox"/> TEV-TROPIN® 5 mg vial with ancillary supplies: <input type="checkbox"/> 30 day supply <input type="checkbox"/> Refill: x _____	
	<input type="checkbox"/> Manual Injection <input type="checkbox"/> Request Inject-Ease® Dose: _____ mg/injection _____ days per week. Dilute: 5 mg TEV-TROPIN® vial with _____ mL/diluent. Inject: _____ mL/ injection. Diluent and injection needles/syringes determined by fulfillment pharmacy unless otherwise indicated. B-D syringes recommended for proper fit for Inject-Ease® . Preferred diluent syringe/needle _____ Preferred injection syringe/needle _____	<input type="checkbox"/> Tjet™ Injection Device (supplies to include: syringe heads, vial adapters, Bact. NaCl practice vial). Sig: Administer prescribed dose as directed. Refill: PRN TEV-TROPIN® sig when using Tjet™. Dilute 5 mg TEV-TROPIN® vial with 1 mL/diluent. Using Tjet™ device, inject _____ mg (must be in even increments of 0.05 mg) _____ days per week.

Injection Training	<input type="checkbox"/> Check if Ordering Home-Based Training (Skilled nurse visit for first dose instruction on TEV-TROPIN® administration for patient.) Injection Training will be/has been conducted by the physician's office? <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____
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Physician Authorization	Prescriber's Signature	Date
	(Practitioner required license # _____) X _____	_____
	DEA#: _____ NPI# _____	
	If NP or PA, under direction of Dr. _____ License # _____	
	Print Prescriber's name:	_____
	Prescriber certifies this is his/her full and usual signature.	

PLEASE NOTE: Completion of this form is not a guarantee of approval. Eligibility verification is the responsibility of the provider. Fax Confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the attached material is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error please notify us immediately by telephone at: