Blue Cross Blue Shield of Montana
Live Smart. Live Healthy.®

PRIME THERAPEUTICS
SPECIALTY PHARMACY™

GROWTH HORMONE REFERRAL FORM

SIGN AND FAX THIS FORM TO 877.828.3939
If you have questions, please call 877.627.MEDS (6337)

PATIENT/PRESCRIBER

PATIENT INFORMATION		PRESCRIBER INFORMATION	
First name: MI:		Title: First name:	
Last name:		Last name:	State license #:
Patient DOB:	Sex:	Provider NPI #:	DEA #:
Address:		Office name:	Office contact:
City/State/Zip:		Address:	
Primary phone:		City/State/Zip:	
Alternate phone:		Phone:	Fax:

PLAN

FAX A COPY OF THE FRONT AND BACK OF ALL INSURANCE CARDS

Primary insurance:	Policy ID #:	Group #:	
Policyholder name:	Policyholder DOB:	PCN:	BIN:

CLINICAL

Primary diagnosis:	Height:	Weight:	Date:
ICD 9:	Allergies:		
Other health conditions:	Current medications:		
Bone age:	Growth velocity:		Date:

PRESCRIPTION INFORMATION

Date needed: ☐ New prescription ☐ Refill prescription ☐ New to therapy ☐ Restarting therapy

Deliver to: ☐ Patient's home ☐ Prescriber's facility ☐ Other:_____

MEDICATION	FORM AND STRENGTH	QTY	DOSE, DIRECTIONS AND FREQUENCY
Genotropin	☐ cartridge _____5 mg _____12 mg ☐ Miniquick PFS _____strength		
Humatrope	☐ 5 mg vial ☐ 12 mg cartridge ☐ 6 mg cartridge ☐ 24 mg cartridge		
Lupron Depot – Ped	☐ 7.5 mg ☐ 11.25 mg ☐ 15 mg ☐ 11.25 mg **or** ☐ 30 mg 3/month kits		
Norditropin Nordiflex Pen	☐ 30 mg		
Norditropin Flexpro Pen	☐ 5 mg ☐ 10 mg ☐ 15 mg		
Nutropin Vial	☐ 5 mg vial ☐ 10 mg vial		
Nutropin AQ Vial/Cartridge	☐ 10 mg vial ☐ 10 mg cartridge ☐ 20 mg cartridge		
Nutropin AQ NuSpin Pen	☐ 5 mg ☐ 10 mg ☐ 20 mg		
Omnitrope	☐ 5.8 mg vial ☐ 5 mg cartridge ☐ 10 mg cartridge		
Saizen	☐ 5 mg vial ☐ 8.8 mg vial ☐ 8.8 mg click.easy cartridge		
Tev-Tropin	☐ 5 mg vial		

☐ Check here if you would like associated supplies dispensed along with injectable medications. **REFILLS: NR 1 2 3 4 5**____
State restrictions apply. Separate prescriptions are required in some jurisdictions.

PRESCRIBER SIGNATURE: PRESCRIBER SIGNATURE IS REQUIRED TO VALIDATE PRESCRIPTIONS.

☐ **Dispense as written/Do not substitute** **Date**

☐ **Substitution permitted/Brand exchange permitted** **Date**

For states requiring hand written expressions of product selection use this area (e.g. medically necessary, may not substitute, dispense as written, etc.).