

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:	<input type="checkbox"/> New prescription	<input type="checkbox"/> Refill prescription	<input type="checkbox"/> New to therapy	<input type="checkbox"/> Restarting therapy
	Deliver to:	<input type="checkbox"/> Patient's home	<input type="checkbox"/> Prescriber's facility	<input type="checkbox"/> Other: _____	
	MEDICATION	FORM AND STRENGTH	QTY	DOSE, DIRECTIONS AND FREQUENCY	
	Genotropin	<input type="checkbox"/> cartridge ____ 5 mg ____ 12 mg <input type="checkbox"/> Miniquick PFS _____ strength			
	Humatrope	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 12 mg cartridge <input type="checkbox"/> 6 mg cartridge <input type="checkbox"/> 24 mg cartridge			
	Lupron Depot – Ped	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 11.25 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 11.25 mg or <input type="checkbox"/> 30 mg 3/month kits			
	Norditropin Nordiflex Pen	<input type="checkbox"/> 30 mg			
	Norditropin Flexpro Pen	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg			
	Nutropin Vial	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 10 mg vial			
	Nutropin AQ Vial/Cartridge	<input type="checkbox"/> 10 mg vial <input type="checkbox"/> 10 mg cartridge <input type="checkbox"/> 20 mg cartridge			
	Nutropin AQ NuSpin Pen	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg			
	Omnitrope	<input type="checkbox"/> 5.8 mg vial <input type="checkbox"/> 5 mg cartridge <input type="checkbox"/> 10 mg cartridge			
	Saizen	<input type="checkbox"/> 5 mg vial <input type="checkbox"/> 8.8 mg vial <input type="checkbox"/> 8.8 mg click.easy cartridge			
Tev-Tropin	<input type="checkbox"/> 5 mg vial				
<input type="checkbox"/> 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.).

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