# **Growth Hormone** Enrollment Form (A-M)

## PATIENT INFORMATION

Patient Name: _____
Date of Birth: _____ / _____ / _____ ☐ Male ☐ Female
SSN: _____ - _____ - _____
Address: _____
City: _____ State: _____ Zip: _____

Phone: ( _____ ) - _____ - _____
Email: _____
Preferred method of contact: ☐ Phone ☐ Email
Height: _____ in Weight: _____ lb Date: _____ / _____ / _____
Allergies: Medications: (Please attach additional pages if necessary)

## PRESCRIPTION BENEFITS INFORMATION (Please attach front and back of insurance card)

Plan name: _____ ID#: _____ Group #: _____ RxBIN: _____ RxPCN: _____

## PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Contact: _____ Clinic/Hospital Affiliation: _____

Phone: ( _____ ) - _____ - _____ Fax: ( _____ ) - _____ - _____
License #: _____
NPI #: _____
Medicaid Provider #: _____

GHAMRX-19-01

## CLINICAL CONSIDERATIONS

Diagnosis:
☐ Q87.1 Congenital malformation syndromes predominantly associated with short stature (includes Prader-Willi or Noonan syndromes)
☐ Q96.9 Turner's Syndrome
☐ R62.52 Short stature (pediatric)
☐ E23.0 Hypopituitarism
☐ E23.1 Drug-induced hypopituitarism
☐ E34.3 Short stature due to endocrine disorder
☐ P05.10 Small for gestational age
☐ N18.9 CKD, unspecified
☐ Other ICD10: _____

Immunization History
☐ Influenza
Date: ____ /____ / ____

Please list previously tried/failed therapies & dates:

**Please indicate patient weight in kilograms: _____ kg**

| Medication | Dose/Strength | | Directions | Quantity | Refills |
|---|---|---|---|---|---|
| ☐ **Genotropin®** (somatropin)<br>Note: Prescriber must order pen/device from manufacturer | ☐ Miniquick | ☐ 0.2 mg ☐ 0.4 mg ☐ 0.6 mg ☐ 0.8 mg ☐ 1 mg ☐ 1.2 mg ☐ 1.4 mg ☐ 1.6 mg ☐ 1.8 mg ☐ 2 mg | ☐ Inject _____ mg subcutaneously once daily _____ times per week | | |
| | | ☐ 31G X 5/16" BD Ultra-Fine pen needles<br>☐ Other: | | | |
| | ☐ Cartridge | ☐ 5 mg ☐ 12 mg | ☐ Inject _____ mg subcutaneously once daily _____ times per week | | |
| | | ☐ 31G X 5/16" BD Ultra-Fine pen needles<br>☐ Other: | | | |
| ☐ **Humatrope®** (somatropin) | ☐ Cartridge | ☐ 6 mg ☐ 12 mg ☐ 24 mg | ☐ Inject _____ mg subcutaneously once daily _____ times per week | | |
| | | ☐ 31G X 5/16" BD Ultra-Fine pen needles<br>☐ Other: | | | |
| | ☐ Vial | ☐ 5 mg | ☐ Inject _____ mg subcutaneously once daily _____ times per week | | |
| | | ☐ 27G X 1/2" BD needle with attached 1 mL syringe ****NOTE: 2 needles/dose needed****<br>☐ 27G X 1/2" BD needle with attached 3 mL syringe<br>☐ Other: | | | |

**Injection Training**
Injection training provided by ☐ Prescriber's Office ☐ Specialty Pharmacy ☐ Other: _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

**Prescriber's Signature:** _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____
NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

## SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic Date Shipment Needed By: ____ /____ / ____