

# Growth Hormone Enrollment Form (N-O)



PATIENT INFORMATION	
Patient Name: _____ Date of Birth: ____/____/____ <input type="checkbox"/> Male <input type="checkbox"/> Female SSN: _____ - _____ - _____ Address: _____ City: _____ State: _____ Zip: _____	Phone: (____) - ____ - _____ Email: _____ Preferred method of contact: <input type="checkbox"/> Phone <input type="checkbox"/> Email Height: _____ in   Weight: _____ lb   Date: ____/____/____ Allergies: _____ Medications: _____ (Please attach additional pages if necessary)

PRESCRIPTION BENEFITS INFORMATION <small>(Please attach front and back of insurance card)</small>		
Plan name: _____	ID#: _____ Group #: _____	RxBIN: _____ RxPCN: _____

PRESCRIBER INFORMATION	
Prescriber Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Contact: _____ Clinic/Hospital Affiliation: _____	Phone: (____) - ____ - _____ Fax: (____) - ____ - _____ License #: _____ NPI #: _____ Medicaid Provider #: _____

CLINICAL CONSIDERATIONS		
Diagnosis: <input type="checkbox"/> Q87.1 Congenital malformation syndromes predominantly associated with short stature (includes Prader-Willi or Noonan syndromes) <input type="checkbox"/> Q96.9 Turner's Syndrome <input type="checkbox"/> R62.52 Short stature (pediatric) <input type="checkbox"/> E23.0 Hypopituitarism	<input type="checkbox"/> E23.1 Drug-induced hypopituitarism <input type="checkbox"/> E34.3 Short stature due to endocrine disorder <input type="checkbox"/> P05.10 Small for gestational age <input type="checkbox"/> N18.9 CKD, unspecified <input type="checkbox"/> Other ICD10: _____	Immunization History <input type="checkbox"/> Influenza Date: ____/____/____  Please list previously tried/failed therapies & dates:

**Rx** Please indicate patient weight in kilograms: \_\_\_\_\_ kg

Medication	Dose/Strength	Directions	Quantity	Refills
<input type="checkbox"/> <b>Norditropin®</b> (somatropin)	<input type="checkbox"/> Flexpro®	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 30G X 1/3" Novofine needles <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Inject _____ mg subcutaneously once daily _____ times per week		
<input type="checkbox"/> <b>Nutropin AQ</b> (somatropin)	<input type="checkbox"/> NuSpin®	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> 31G X 5/16" BD Ultra-Fine pen needles <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Inject _____ mg subcutaneously once daily _____ times per week <input type="checkbox"/> 31G X 5/16" BD Ultra-Fine pen needles		
<input type="checkbox"/> <b>Omnitrope®</b> (somatropin)	<input type="checkbox"/> Cartridge	<input type="checkbox"/> 5 mg / 1.5 mL <input type="checkbox"/> 10 mg / 1.5 mL <input type="checkbox"/> 31G X 5/16" BD Ultra-Fine pen needles <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Inject _____ mg subcutaneously once daily _____ times per week		
Note: Prescriber must order pen/device from manufacturer	<input type="checkbox"/> Vial	<input type="checkbox"/> 5.8 mg <input type="checkbox"/> Mixing: 25G X 5/8" needle with 2 mL Luer-Lock syringe Injecting: 27G X 1/2" needle with 1 mL syringe <input type="checkbox"/> Other: _____		
		<input type="checkbox"/> Inject _____ mg subcutaneously once daily _____ times per week		

**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: <input type="checkbox"/> Patient <input type="checkbox"/> Physician/Clinic	Date Shipment Needed By: ____/____/____