Growth Hormone Enrollment Form (P-Z)

PRx

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 #: _____

GHPZRX-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
☐ **Saizen®** (somatropin)	☐ Saizenprep® Cartridge	☐ 8.8 mg	☐ Inject _____ mg subcutaneously once daily _____ times per week		
		☐ 29G X 1/2" pen needles (for use with the One.Click Pen delivery system) ☐ Other:			
	☐ Vial	☐ 5 mg ☐ 8.8 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**** ☐ 27G X 1/2" BD needle with attached 3 mL syringe ☐ Other:			
☐ **Zomacton®** (somatropin)	☐ Vial	☐ 5 mg ☐ 10 mg w/ 25G reconstitution needle ☐ 10 mg w/ vial adapter	☐ Inject _____ mg subcutaneously once daily _____ times per week		
		☐ 27G X 1/2" BD needle with attached 1 mL syringe ****NOTE: 2 needles/dose needed**** ☐ 27G X 1/2" BD needle with attached 3 mL syringe ☐ 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: ____ / ____ / ____

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