Growth Disorders - Pediatric Indication

PRESCRIPTION & ENROLLMENT FORM

❑ New Patient
❑ Current

❶ PATIENT INFORMATION

Patient's Name ______
Date of Birth ______ ❑ Male ❑ Female Last 4 digits of SSN______
Street Address ______ Apt#______
City ______ State ______ Zip ______
Parent/Guardian (if applicable) ______
Home Phone ______ Work Phone ______
Cell Phone ______ Evening Phone ______
E-mail address ______
Insurance Company Name ______
Insurance Company Phone No. ______
Insured's Name ______
Insured's Employer ______
Relationship to Patient ______
Identification No.______ Policy/Group No.______
Prescription Card ❑ No ❑ Yes If Yes, Carrier ______
Policy No. ______ Group No. ______
Is patient eligible for Medicare? ❑ No ❑ Yes **Please attach front and back copy of patient's insurance cards, if available.**

❷ PRESCRIBER INFORMATION

Prescriber's Name ______
Office Contact ______
Clinic / Hospital Affiliation ______
Street Address______Suite # ______
City ______ State ______ Zip ______
Phone ______ Fax ______
NPI No. ______ License No.______
DEA No. ______
Physician Medicaid UPIN No.______
MD Specialty ______

To reach your team, call toll-free **1 877 218-0410**.

Please fax completed form to the Growth Disorder team 1 888 355-6682.

❸ CLINICAL INFORMATION

PRIMARY DIAGNOSIS (CHECK ONE) ❑ Adult ❑ Pediatric
Diagnosis: ______

Weight (kg) ______ Height (cm) ______

Please attach information for Growth Disorder Diagnosis:

- **Current History/Physical and Clinic Notes**
- **Growth Charts/Velocity**
- **Bone Age**
- **GH Stimulation Test Results**
- **IGF-I Results**
- **Other Laboratory Results**

PRESCRIPTION

❑ Genotropin Pen® 5/5.8 mg Cartridge
❑ Genotropin Mixer Device® 5/5.8 mg Cartridge
❑ Genotropin Pen® 12/13.8 mg Cartridge
❑ Genotropin Mixer Device® 12/13.8 mg Cartridge
❑ Genotropin Mini Quick® ______ mg
❑ Humatrope® 5 mg Vial
❑ Humatrope® 6 mg Cartridge
❑ Humatrope® 12 mg Cartridge
❑ Humatrope® 24 mg Cartridge
❑ Increlex® 40 mg/4mL
❑ Lupron® _____ mg
❑ Lupron Depot® _____ mg
❑ Lupron Depot Ped® _____ mg
❑ Nordiflex Disposable Pen® 5 mg
❑ Nordiflex Disposable Pen® 10 mg
❑ Nordiflex Disposable Pen® 15 mg
❑ Norditropin Pen/Cartridge® 5 mg
❑ Norditropin Pen/Cartridge® 15 mg
❑ Nutropin® 5 mg Vial
❑ Nutropin® 10 mg Vial
❑ Nutropin AQ® 10 mg/2 mL Vial
❑ Nutropin AQ® 10 mg/2mL Pen/Cartridge
❑ Nutropin AQ® 20 mg/2 mL Pen/Cartridge
❑ Omnitrope® 1.5 mg vial
❑ Omnitrope® 5.8 mg vial
❑ Saizen® 5 mg Vial
❑ Saizen® 5 mg with Cool-Click
❑ Saizen® 8.8 mg Vial
❑ Saizen® 8.8 mg with Cool-Click
❑ Saizen® One Click 8.8 mg
❑ Serostim®
❑ Tev-Tropin® 5 mg Vial

Any other device used? *(check one if applicable)* ❑ Injectease ❑ Genjects
Note: Prescription to include all necessary ancillary supplies (i.e. needles, syringes and pen devices)
Diluent Amount ______ Injection Volume ______
Dose ______ mg ______ days/week Dose ______ mg / kg / wk
Dispense ______ months supply Refill ______ times or through ______ (date)
Specific administration supply (gauge) ______
Note to TN prescribers - Quantity must be written in both numerals and words (ex. 3(three) doses)

SHIP DRUG TO: ❑ Physician's Office ❑ Patient's Home
(If shipped to physician's office, physician accepts on behalf of patient for administration in office.)
Injection Training ❑ **Yes** ❑ **No**
By: ❑ MD Office ❑ Alternate Agency ______
❑ Accredo ❑ Agency Phone ______

I certify that the prescribed Growth Hormone Product is not for cosmetic, anti-aging or athletic enhancement purposes and is medically necessary for the replacement of endogenous Growth Hormone secondary to GH deficiency and I will be supervising the patient's treatment accordingly.

Prescriber's Printed Name ______
Prescriber's Signature (sign below) **Date** ______

______ **Dispense as Written** ______ **Substitution Allowed**

(Physician attests this is his/her legal signature. **NO STAMPS)**

Accredo Health Group, Inc., is a wholly owned subsidiary of Medco Health Solutions, Inc.
© 2008 Medco Health Solutions, Inc. All rights reserved.
GDT-00002-082508