Prescription & Enrollment Form

Adult Growth Disorders

accredo®

677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 PATIENT INFORMATION

❑ New patient ❑ Current

Patient's first name _____
Last name _____ Middle initial _____
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 _____
Patient's primary language: ❑ English ❑ Other If other, please specify _____

Please attach copies of front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
Insured's name _____
Insured's employer _____
Relationship to patient _____
Identification # _____ Policy/group # _____
Prescription card: ❑ Yes ❑ No If yes, carrier _____
Policy # _____ Group # _____
Is patient eligible for Medicare? ❑ Yes ❑ No
Does patient have a secondary insurance? ❑ Yes ❑ No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed by _____
Prescriber's first name _____ Last name _____
Middle initial _____ Prescriber's title _____
If NP or PA, under direction of Dr. _____
Office contact and title _____
Office contact e-mail _____ Clinic/hospital affiliation _____
Office/clinic/institution name _____
Street address _____ Suite # _____
City _____ State ____ Zip _____
Phone _____ Fax _____
NPI # _____ License # _____
Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic
Clinic location _____

3 CLINICAL INFORMATION

Primary ICD-10 code: _____
Weight (kg) _____ Height (cm) _____ Date measured _____
Injection training needed: ❑ Yes ❑ No By: ❑ MD office ❑ Other _____
If prior HgH use, date started _____
❑ NKDA ❑ Known drug allergies _____
Concurrent meds _____

Please attach the following information for growth disorder diagnosis:
Drug profile, labs, growth chart where applicable

4 PRESCRIBING INFORMATION

Medication	Directions	Quantity/Refills
❑ Genotropin® (somatropin) cartridge ❑ 5mg ❑ 12mg ❑ Genotropin (somatropin) Mini Quick® prefilled syringe ❑ 0.2mg ❑ 0.4mg ❑ 0.6mg ❑ 0.8mg ❑ 1mg ❑ 1.2mg ❑ 1.4mg ❑ 1.6mg ❑ 1.8mg ❑ 2mg ❑ Humatrope® (somatropin) 5mg vial ❑ Humatrope (somatropin) cartridge ❑ 6mg ❑ 12mg ❑ 24mg ❑ HumatroPen® (somatropin) injection device for cartridge ❑ 6mg ❑ 12mg ❑ 24mg ❑ Increlex® (mecasermin) 40mg/4mL vial ❑ Norditropin® (somatropin) FlexPro® prefilled pen ❑ 5mg ❑ 10mg ❑ 15mg ❑ 30mg ❑ Nutropin (somatropin) AQ Pen® cartridge 20mg/2mL ❑ Nutropin (somatropin) AQ NuSpin® prefilled device ❑ 5mg ❑ 10mg ❑ 20mg ❑ Omnitrope® (somatropin) 5.8mg vial ❑ Omnitrope (somatropin) cartridge ❑ 5mg/1.5mL ❑ 10mg/1.5mL ❑ Saizen® (somatropin) ❑ 5mg vial ❑ 8.8mg vial ❑ 8.8mg cartridge ❑ Zomacton® (somatropin) ❑ 5mg vial ❑ 10mg vial ❑ Other _____		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other _____ Refills _____
	Ancillary Supplies	**Quantity/Refills**
	❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed.	Send quantity sufficient for medication days supply

If shipped to physician's office, physician accepts on behalf of patient for administration in office.

By signing below, I certify that the above therapy is medically necessary. I also authorize Accredo to initiate any de minimus authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans, to the extent not prohibited.

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. **NO STAMPS**)

PHYSICIAN SIGNATURE REQUIRED

_____ _____ _____ _____
Date Dispense as written Date Substitution allowed

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

Please fax completed form to the Growth Disorder team 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

GDT-00001-H-112320 amc6224

FOR REFERENCE ONLY: **This page is for reference only and should not be returned. Diagnosis must be indicated in section 3 of the enrollment form.**

COMMON DIAGNOSIS CODES

B20 Human immunodeficiency virus [HIV] disease
With: **R64** Cachexia (Serostim® only)
With: **E88.1** Lipodystrophy (Egrifta® only)

E23.0 Idiopathic growth hormone deficiency:
• Childhood-onset • Adult-onset
E34.3 Short stature due to endocrine disorder

E23.0 Acquired growth hormone deficiency with:
• Childhood-onset • Adult-onset
C75.1 Malignant neoplasm of pituitary gland
C75.2 Malignant neoplasm of craniopharyngeal duct
D35.2 Benign neoplasm of pituitary gland
D35.3 Benign neoplasm of craniopharyngeal duct
E23.0 Hypopituitarism
E23.1 Drug-induced hypopituitarism
E89.3 Postprocedural hypopituitarism
E23.3 Hypothalamic dysfunction

N18.9 Chronic kidney disease (child, pre-transplant):
• HD • CAPD • CCPD, schedule: _____
N18.2 CKD, Stage II (Mild)
N18.3 CKD, Stage III (Moderate)
N18.4 CKD, Stage IV (Severe)
N18.5 CKD, Stage V
N18.6 End stage renal disease

Congenital disease & associated disorders:
Q96.9 Turner's syndrome
Q87.1 Noonan syndrome
Q87.1 Prader-Willi syndrome
E34.3, Q78.8 SHOX deficiency
Q87.1 Russell-Silver syndrome
Q89.8 Other specified congenital malformations

R62.50 Severe IGF-1 deficiency (Increlex® only)

R62.52 Small for Gestational Age with inadequate catch-up growth (child):
P05.10 Small for gestational age
P05.00 Light for gestational age
P05.9 Slow intrauterine growth

R62.52 Idiopathic Short Stature (child) with – 2.25 SDS

K91.2 Short-bowel Syndrome (Zorbtive® only)