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Prescription & Enrollment Form

Pediatric Growth Disorders

accredo[®]

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

Four simple steps to submit your referral.

1 Patient Information



Please provide copies of front and back of all medical and prescription insurance cards.

New patient Current patient

Patient's first name _____ Last name _____ Middle initial _____

Sex at birth: Male Female Pronouns _____ Last 4 digits of SSN _____ Date of birth _____

Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

OK to leave message with alternate caregiver/contact

Patient's primary language: English Other If other, please specify _____

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: Prescriber's office Patient's home

3 Clinical Information

Primary ICD-10 code (REQUIRED): _____ 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

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

Medication	Strength/Formulation	Directions	Quantity/Refills
Genotropin® (somatropin)	5mg cartridge 12mg cartridge		1-month supply 3-month supply Other _____ Refills _____
	Mini Quick® prefilled syringe 0.2mg (1-mo) 0.4mg 0.6mg 0.8mg 1mg 1.2mg (1-mo) 1.4mg 1.6mg 1.8mg 2mg		
Humatrope® (somatropin)	5mg vial 6mg cartridge 12mg cartridge 24mg cartridge		
HumatroPen® (somatropin) injection device for cartridge	6mg device 12mg device 24mg device		
Increlex® (mecasermin)	40mg/4mL vial		
Norditropin® (somatropin)	FlexPro® prefilled pen 5mg 10mg 15mg 30mg		
Nutropin (somatropin)	AQ Pen® cartridge 20mg/2mL		
	AQ NuSpin® prefilled device 5mg 10mg 20mg		
Omnitrope® (somatropin)	5.8mg vial 5mg/1.5mL cartridge 10mg/1.5mL cartridge		
Sogroya® (somapacitan- beco)	Prefilled pen 5mg 10mg 15mg		
Skytrofa® (lonapegsoma- tropin-tcgd)	3mg cartridge 3.6mg cartridge 4.3mg cartridge		
	5.2mg cartridge 6.3mg cartridge 7.6mg cartridge		
	9.1mg cartridge 11mg cartridge 13.3mg cartridge		
Zomacton® (somatropin)	5mg vial 10mg vial		
Other		1-month supply 3-month supply Other _____ Refills _____	
Ancillary Supplies: (Prescriber to strike through if not required) Dispense ancillary supplies such as needles, syringes, sterile water, etc. and home medical equipment necessary to administer the therapy as needed.			Send quantity sufficient for mediation days supply

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

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 required (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

**SIGN
HERE**

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.



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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)