Please fax all pages of completed form to your team at 888.302.1028.
To reach your team, call toll-free 844.516.3319.
You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Accredo® Specialty Pharmacy Prescription & Enrollment Form

Pediatric Growth Disorders

EVERNORTH HEALTH SERVICES

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 _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ 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 _____

Provider will read the following statement to patient: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

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		
☐ Ngenla® (somatrogon-ghla)	☐ 24mg/1.2mL Prefilled Pen ☐ 60mg/1.2mL Prefilled Pen		
☐ Norditropin® (somatropin)	**FlexPro® prefilled pen** ☐ 5mg ☐ 10mg ☐ 15mg ☐ 30mg		
☐ 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)	☐ 0.7mg cartridge ☐ 1.4mg cartridge ☐ 1.8mg cartridge ☐ 2.1mg cartridge ☐ 2.5mg cartridge ☐ 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 medication 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.

EVERNORTH HEALTH SERVICES

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)