Please fax both 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.

Prescription & Enrollment Form

Pediatric Growth Disorders

accredo®

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 ______

Male Female Last 4 digits of SSN ______ Date of birth ______

Street address ______ Apt # ______

City ______ State ______ Zip ______

Home phone ______ Cell phone ______ E-mail address ______

Parent/guardian (if applicable) ______

Home phone ______ Cell phone ______ E-mail address ______

Alternate caregiver/contact ______

Home phone ______ Cell phone ______ E-mail 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 ______

Prescriber's first name ______ Last name ______

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

Phone ______ Fax ______

Office/clinic/institution name ______ Office/clinic/institution affiliation ______

Office address ______ Suite # ______

City ______ State ______ Zip ______

Office contact and title ______

Office contact phone number ______ Office contact e-mail ______

Fax ______ NPI # ______ License # ______

Deliver product to: 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	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 Skytrofa® (lonapegsomatropin-tcgd) cartridge 3mg 3.6mg 4.3mg 5.2mg 6.3mg 7.6mg 9.1mg 11mg 13.3mg Zomacton® (somatropin) 5mg vial 10mg vial Other		1-month supply 3-month supply Other ______________ Refills ______________
	Ancillary Supplies	**Quantity/Refills**
leuprolide 5mg/mL, 2.8mL multi-dose vial, 14-day kit Lupron Depot Ped® (leuprolide) 7.5mg 28 day 11.25mg 28 day 11.25mg 84 day 15mg 28 day 30mg 84 day	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 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.

accredo®

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. All rights in the product names, trade names or logos of all third-party products that appear in this form, whether or not appearing with the trademark symbol, belong exclusively to their respective owners. © 2022 Accredo Health Group, Inc. I An Express Scripts Company. All rights reserved. GDT-00002-042222 amc6224 CRP2204_0015395.1

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)