AcariaHealth
Specialty Pharmacy

Phone: 800.511.5144 • Fax: 877.541.1503

Date Shipment Needed: _____ Ship To: ❑Patient ❑Prescriber
❑ Nursing needed; ❑Training needed ► All the supplies including syringes and needles will be dispensed if needed.

GROWTH HORMONE REFERRAL FORM

PATIENT INFORMATION

Patient Name:		DOB:	Sex: ❑M ❑F	Weight:	❑lbs. ❑kg.
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip:	
Emergency Contact:		Phone:	❑ **Please attach demographic information**		

PRESCRIBER INFORMATION

Prescriber:	NPI:	DEA:	State Lic:
Supervising Physician:		Practice Name:	
Address:		City:	State:	Zip:
Phone:	Fax:	Key Office Contact:	Phone:

DIAGNOSIS INFORMATION / MEDICAL ASSESMENT

Primary Diagnosis: (ICD-10 Code & Description) _____

❑Growth Hormone Deficiency ❑Short Bowel Syndrome ❑Growth Failure d/t PWS (Prader-Willi Syndrome) ❑Central Precocious Puberty
❑Growth Failure d/t Chronic Renal Insufficiency up to the time of renal transplantation ❑Short Stature associated with Turner Syndrome ❑Idiopathic Short Stature
❑Other: _____

- Has patient been treated *previously* for this condition? ❑Yes ❑No Medication(s): _____
- Is patient *currently* on therapy? ❑Yes ❑No Medication(s): _____
- Will patient stop taking the above medication(s) before starting the new medication? ❑Yes ❑No If yes: _____
- How long should patient wait before starting the new medication? _____
- Other medications patient is currently taking including OTC medications with dosage and direction (or fax medication profile):

_____

INSURANCE INFORMATION

❑ **Please attach front and back of patient's insurance card (medical and prescription)**

COPAY CARD ENROLLMENT

❑ **Please check if enrolling in copay card**	**Copay ID:**

PRESCRIPTION INFORMATION

❑Genotropin Pen ® (two-chamber cartridge) — **❑Enroll in Pfizer BRIDGE Program®**
❑5 mg/mL (green pen) ❑12 mg/mL (purple pen) QTY: _____ Refills:_____

❑Genotropin Miniquick®
❑0.2 mg ❑0.4 mg ❑0.6 mg ❑0.8 mg ❑1 mg ❑1.2 mg ❑1.4 mg ❑1.6 mg ❑1.8 mg ❑2 mg QTY: _____ Refills:_____

❑Humatrope Powder with Diluent — **❑Enroll in Humatrope DirectConnect**
❑5 mg/mL vial ❑6 mg cartridge (gold) ❑12 mg cartridge (teal) ❑24 mg cartridge (purple) QTY: _____ Refills:_____

❑Increlex 40 mg/4 mL **Note: maximum dose of 0.12 mg/kg SQ twice daily, injection should be administered shortly (20 min) before or after a meal or snack* — **❑Enroll in IPSEN Cares Program**

❑Lupron Depot-Ped
❑7.5 mg ❑11.25 mg ❑11.25 mg ❑15 mg ❑30 mg QTY: _____ Refills:_____

❑Norditropin ® FlexPro® — **❑Enroll in NordiCARE® Program**
❑5 mg/1.5 mL (orange) ❑10 mg/1.5 mL (blue) ❑15 mg/1.5 mL (green) ❑30 mg/3 mL (purple) QTY: _____ Refills:_____

❑NuSpin® — **❑Enroll in NuAccess℠ Program**
❑5 mg/2 mL (clear) ❑10 mg/2 mL (green) ❑20 mg/2 mL (blue) QTY: _____ Refills:_____

❑Nutropin AQ® Pen Cartridge
❑10 mg/2 mL (yellow) ❑20 mg/2 mL (purple) QTY: _____ Refills:_____

❑Omnitrope® — **❑Enroll in MyOmniSource™**
❑5 mg/1.5 mL cartridge for Pen 5 (dark blue) ❑10 mg/1.5 mL for Pen 10 (light blue) powder with diluent ❑5.8 mg/vial QTY: _____ Refills:_____

❑Saizen® Poweder with Diluent **Vial contains M-Cresol preservative* — **❑Enroll in Connections for Growth®**
❑5 mg/vial* ❑8.8 mg/vial* ❑Click Easy Cartridge 8.8 mg QTY: _____ Refills:_____

❑Zomacton™ Powder with Diluent — **❑Enroll in ZOGO Support Program**
❑5 mg/vial (Benzyl alcohol preservative) ❑10 mg/vial (0.33% metacresol preservative) QTY: _____ Refills:_____

❑Zorbtive Powder with Diluent — **❑Enroll in SeroCare℠**
❑8.8 mg/vial *Note: Max dose of 8 mg/day; max duration of 4 weeks* QTY: _____ Refills:_____

❑Other: _____ QTY: _____ Refills:_____

Prescriber's Signature: _____ ❑ DAW (Dispense as Written) **Date:** _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. NO STAMPED SIGNATURES WILL BE ACCEPTED. Where required by law, send prescription on official state prescription blank. In the event requested agent is not available through AcariaHealth, this prescription shall be forwarded to an eligible pharmacy.

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