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 ASSESEMENT

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

Medication	Program	QTY	Refills
❑Genotropin Pen ® (two-chamber cartridge) ❑5 mg/mL (green pen) ❑12 mg/mL (purple pen)	**❑Enroll in Pfizer BRIDGE Program®**	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 ❑5 mg/mL vial ❑6 mg cartridge (gold) ❑12 mg cartridge (teal) ❑24 mg cartridge (purple)	**❑Enroll in Humatrope DirectConnect**	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® ❑5 mg/1.5 mL (orange) ❑10 mg/1.5 mL (blue) ❑15 mg/1.5 mL (green) ❑30 mg/3 mL (purple)	**❑Enroll in NordiCARE® Program**	QTY: _____	Refills:_____
❑NuSpin® ❑5 mg/2 mL (clear) ❑10 mg/2 mL (green) ❑20 mg/2 mL (blue)	**❑Enroll in NuAccess℠ Program**	QTY: _____	Refills:_____
❑Nutropin AQ® Pen Cartridge ❑10 mg/2 mL (yellow) ❑20 mg/2 mL (purple)		QTY: _____	Refills:_____
❑Omnitrope® ❑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	**❑Enroll in MyOmniSource™**	QTY: _____	Refills:_____
❑Saizen® Poweder with Diluent **Vial contains M-Cresol preservative* ❑5 mg/vial* ❑8.8 mg/vial* ❑Click Easy Cartridge 8.8 mg	**❑Enroll in Connections for Growth®**	QTY: _____	Refills:_____
❑Zomacton™ Powder with Diluent ❑5 mg/vial (Benzyl alcohol preservative) ❑10 mg/vial (0.33% metacresol preservative)	**❑Enroll in ZOGO Support Program**	QTY: _____	Refills:_____
❑Zorbtive Powder with Diluent ❑8.8 mg/vial *Note: Max dose of 8 mg/day; max duration of 4 weeks*	**❑Enroll in SeroCare℠**	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 receiving pharmacy, this prescription shall be forwarded to an eligible pharmacy.

IMPORTANT NOTICE: This message may contain privileged and confidential information and is intended only for the individual named. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document by mistake, then destroy this document.