

Growth Hormone Enrollment Form



Fax Referral To: 1-877-232-5455

Address: 500 Ala Moana Blvd., Ste 1-A Honolulu, HI 96813

Phone: 1-800-896-1464

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: _____ Address: _____ City, State, ZIP: _____

Preferred Contact Methods: Phone (to primary # provided below) Text (to cell # provided below) Email (to email provided below)

Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____ DOB: _____ Gender: Male Female

Email: _____ Last Four of SSN: _____ Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

NPI #: _____ DEA #: _____ Group or Hospital: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Fax: _____ Contact Person: _____ Contact's Phone: _____

3 INSURANCE INFORMATION *Please fax copy of prescription and insurance cards with this form, if available (front and back)*

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: _____ Ship to: Patient Office Other: _____

Diagnosis (ICD-10):

E23.0 Hypopituitarism

N18.9 Chronic Kidney Disease, Unspecified

P05.10 Small Gestational Age

Q87.1 Prader-Willi Syndrome

Q87.89 Other Specified Congenital Malformation Syndromes, Not Elsewhere Classified

Q89.8 Other Specified Congenital Malformations

Q96.9 Turner Syndrome

R62.52 Idiopathic Short Stature (ISS)

Other Code: ____ Description _____

Patient Clinical Information:

Allergies: _____

Height: ____ in/cm

Weight: ____ lb/kg

Nursing:

Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? Yes No

Site of Care: MD office Infusion Clinic Outpatient Health Home Health

Injection training not necessary. Date training occurred: _____

Reason: MD office training patient Pt already independent Referred by MD to alternate trainer

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Please complete Patient and Prescriber information

Patient Name: _____

Patient DOB: _____

Prescriber Name: _____

Prescriber Phone: _____

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
<input type="checkbox"/> Genotropin Note: Prescriber must order pen/device from manufacturer	<input type="checkbox"/> 5 mg pen cartridge <input type="checkbox"/> 12 mg pen cartridge <input type="checkbox"/> 0.2 mg MiniQuick <input type="checkbox"/> 0.4 mg MiniQuick <input type="checkbox"/> 0.6 mg MiniQuick <input type="checkbox"/> 0.8 mg MiniQuick <input type="checkbox"/> 1.0 mg MiniQuick <input type="checkbox"/> 1.4 mg MiniQuick <input type="checkbox"/> 1.6 mg MiniQuick <input type="checkbox"/> 1.8 mg MiniQuick <input type="checkbox"/> 2.0 mg MiniQuick	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> Humatrope	<input type="checkbox"/> 6 mg cartridge kit <input type="checkbox"/> 12 mg cartridge kit <input type="checkbox"/> 24 mg cartridge kit	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> HumatroPen	<input type="checkbox"/> 6 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> 24 mg	Use as directed with Humatrope cartridge	Quantity: _____
<input type="checkbox"/> Increlex	40 mg/4 mL vial	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> Norditropin FlexPro	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> Nutropin AQ Nuspin	<input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> Omnitrope Note: Prescriber must order pen/device from manufacturer	<input type="checkbox"/> 5 mg/1.5 mL cartridges <input type="checkbox"/> 10 mg/1.5 mL cartridges <input type="checkbox"/> 5.8 mg/vial	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> Saizen Note: Prescriber must order pen/device from manufacturer	<input type="checkbox"/> 5 mg vial kit and diluent amount (1mL – 3mL): _____ <input type="checkbox"/> 8.8 mg vial kit and diluent amount (2mL – 3mL): _____ <input type="checkbox"/> 8.8 mg Saizenprep MDV	_____ mg SC _____ days/week	Quantity: _____ Refills: _____
<input type="checkbox"/> Zomacton	<input type="checkbox"/> 5 mg vial and diluent amount (1mL – 5mL): _____ <input type="checkbox"/> 10 mg vial	_____ mg SC _____ days/week	Quantity: _____ Refills: _____

 Patient is interested in patient support programs

STAMP SIGNATURE NOT ALLOWED

Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X _____

X _____

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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