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
☐ P05.10 Small Gestational Age
☐ Q87.89 Other Specified Congenital Malformation Syndromes, Not Elsewhere Classified
☐ Q89.8 Other Specified Congenital Malformations
☐ R62.52 Idiopathic Short Stature (ISS)
☐ N18.9 Chronic Kidney Disease, Unspecified
☐ Q87.1 Prader-Willi Syndrome
☐ Q96.9 Turner Syndrome
☐ 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
☐ Genotropin Note: Prescriber must order pen/device from manufacturer	☐ 5 mg pen cartridge ☐ 12 mg pen cartridge ☐ 0.2 mg MiniQuick ☐ 0.4 mg MiniQuick ☐ 0.6 mg MiniQuick ☐ 0.8 mg MiniQuick ☐ 1.0 mg MiniQuick ☐ 1.4 mg MiniQuick ☐ 1.6 mg MiniQuick ☐ 1.8 mg MiniQuick ☐ 2.0 mg MiniQuick	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ Humatrope	☐ 6 mg cartridge kit ☐ 12 mg cartridge kit ☐ 24 mg cartridge kit	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ HumatroPen	☐ 6 mg ☐ 12 mg ☐ 24 mg	Use as directed with Humatrope cartridge	Quantity:_______
☐ Increlex	40 mg/4 mL vial	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ Norditropin FlexPro	☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 30 mg	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ Nutropin AQ NuSpi	☐ 5 mg ☐ 10 mg ☐ 20 mg	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ Omnitrope Note: Prescriber must order pen/device from manufacturer	☐ 5 mg/1.5 mL cartridges ☐ 10 mg/1.5 mL cartridges ☐ 5.8 mg/vial	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ Saizen Note: Prescriber must order pen/device from manufacturer	☐ 5 mg vial kit and diluent amount (1mL – 3mL): ____ ☐ 8.8 mg vial kit and diluent amount (2mL – 3mL): ____ ☐ 8.8 mg Saizenprep MDV	____mg SC ____ days/week	Quantity:_______ Refills:________
☐ Sogroya	10 mg/1.5 mL	____mg SC ___ days/week	Quantity:_______ Refills:________
☐ Zomacto	☐ 5 mg vial and diluent amount (1mL – 5mL): ____ ☐ 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)

X______________________________

DISPENSE AS WRITTEN (Date)

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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