

Growth Hormone Enrollment Form



Fax Referral To: 1-855-297-1270

Phone: 1-888-280-1190

Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

NCPDP: 4026325

Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____ Gender: Male Female

Address: _____ City, State, ZIP Code: _____

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

Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.

Primary Phone: _____ Alternate Phone: _____

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

Parent/Caregiver/Legal Guardian Name (Last, First): _____ Relationship to patient: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____

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

Address: _____ City, State, ZIP Code: _____

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):

- | | |
|---|--|
| <input type="checkbox"/> E23.0 Hypopituitarism | <input type="checkbox"/> N18.9 Chronic Kidney Disease, Unspecified |
| <input type="checkbox"/> P05.10 Small Gestational Age | <input type="checkbox"/> Q87.1 Prader-Willi Syndrome |
| <input type="checkbox"/> Q87.89 Other Specified Congenital Malformation Syndromes, Not Elsewhere Classified | |
| <input type="checkbox"/> Q89.8 Other Specified Congenital Malformations | <input type="checkbox"/> Q96.9 Turner Syndrome |
| <input type="checkbox"/> R62.52 Idiopathic Short Stature (ISS) | <input type="checkbox"/> Other Code: ____ Description _____ |

Patient Clinical Information:

Allergies: _____ Weight: ____lb/kg Height: ____in/cm

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: _____ Patient Phone: _____

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"/> Ngenla	<input type="checkbox"/> 24 mg/1.2 mL <input type="checkbox"/> 60 mg/1.2 mL	_____mg SC once weekly	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"/> Skytrofa Note: Prescriber must order pen/device from manufacturer	<input type="checkbox"/> 3 mg cartridges <input type="checkbox"/> 3.6 mg cartridges <input type="checkbox"/> 4.3 mg cartridges <input type="checkbox"/> 5.2 mg cartridges <input type="checkbox"/> 6.3 mg cartridges <input type="checkbox"/> 7.6 mg cartridges <input type="checkbox"/> 9.1 mg cartridges <input type="checkbox"/> 11 mg cartridges <input type="checkbox"/> 13.3 mg cartridges	_____mg SC once weekly	Quantity: _____ Refills: _____
<input type="checkbox"/> Sogroya	<input type="checkbox"/> 5 mg/1.5 mL <input type="checkbox"/> 10 mg/1.5 mL <input type="checkbox"/> 15 mg/1.5 mL	_____mg SC once weekly	Quantity: _____ Refills: _____
<input type="checkbox"/> Zomacton	<input type="checkbox"/> 5 mg vial and diluent amount (1 mL – 5 mL): _____ <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 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute Prescriber's Signature: _____ Date: _____	May Substitute / Product Selection Permitted / Substitution Permissible Prescriber's Signature: _____ Date: _____
CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "No Substitution" ATTN: New York and Iowa providers, please submit electronic prescription	

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.

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