Growth Hormone Enrollment Form

CVS specialty®

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com

Phone: 1-800-237-2767

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):

☐ 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: _____ 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
☐ 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:_____
☐ Ngenla	☐ 24 mg/1.2 mL ☐ 60 mg/1.2 mL	____mg SC once weekly	Quantity:_____ Refills:_____
☐ Norditropin FlexPro	☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 30 mg	____mg SC ____ days/week	Quantity:_____ Refills:_____
☐ Nutropin AQ Nuspin	☐ 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:_____
☐ Skytrofa Note: Prescriber must order pen/device from manufacturer	☐ 3 mg cartridges ☐ 3.6 mg cartridges ☐ 4.3 mg cartridges ☐ 5.2 mg cartridges ☐ 6.3 mg cartridges ☐ 7.6 mg cartridges ☐ 9.1 mg cartridges ☐ 11 mg cartridges ☐ 13.3 mg cartridges	____mg SC once weekly	Quantity:_____ Refills:_____
☐ Sogroya	☐ 5 mg/1.5 mL ☐ 10 mg/1.5 mL ☐ 15 mg/1.5 mL	____mg SC once weekly	Quantity:_____ Refills:_____
☐ Zomacton	☐ 5 mg vial and diluent amount (1 mL – 5 mL): ____ ☐ 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.