

<b>TODAY'S DATE:</b>
<b>DATE SHIPMENT NEEDED:</b>
<input type="checkbox"/> <b>NEW START</b> <input type="checkbox"/> <b>CONTINUATION OF THERAPY</b>
<b>SHIP TO:</b> <input type="checkbox"/> PATIENT <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> KERR DRUG STORE: _____

## Growth Hormone Referral Form

### GENERAL INFORMATION

<b>PATIENT (FIRST NAME, LAST NAME):</b>		ADDRESS:	
CITY:	STATE:	ZIP:	DOB:
SS#:	HOME#:	CELL#:	WORK#:
ALLERGIES:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT:	WEIGHT:
CURRENT MEDS:			
CAN PHARMACY LEAVE A VOICEMAIL? <input type="checkbox"/> YES <input type="checkbox"/> NO    VOICEMAIL PHONE #:			
<b>PHYSICIAN NAME:</b>		PRACTICE NAME/HOSPITAL:	
ADDRESS:	CITY:	STATE:	ZIP:
PHONE#:	FAX#:	STATE LIC#:	DEA#:
NURSE/KEY OFFICE CONTACT:		NPI#:	

### PRESCRIPTION INSURANCE INFORMATION

<b>PRIMARY INSURANCE:</b>		EMPLOYER:	
CARDHOLDER NAME:	ID#:	GROUP#:	PHONE#:
<b>SECONDARY INSURANCE:</b>	ID#:	GROUP#:	PHONE#:

### STATEMENT OF MEDICAL NECESSITY

DIAGNOSIS WITH ICD 9:  \_\_\_\_\_ EPIPHYSIS OPEN:     YES     NO    BONE AGE: \_\_\_\_\_

GROWTH VELOCITY: \_\_\_\_\_ STIM TEST #1/DATE/PASS OR FAIL: \_\_\_\_\_ STM TEST #2/DATE/PASS OR FAIL: \_\_\_\_\_

### PRESCRIPTION INFORMATION

<input type="checkbox"/> <b>Humatrope®</b> (subQ inj) <input type="checkbox"/> 5 mg vials <input type="checkbox"/> 6 mg cartridge kit <input type="checkbox"/> 12 mg cartridge kit <input type="checkbox"/> 24 mg cartridge kit <input type="checkbox"/> Other _____ Qty: _____ Refills: _____	<input type="checkbox"/> <b>Norditropin®</b> <input type="checkbox"/> NordiFlex® multidose disp pen <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> NordiPen® <input type="checkbox"/> 5 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> Needle Size <input type="checkbox"/> 30 g <input type="checkbox"/> 31 g <input type="checkbox"/> NordiPenMate® Sig: _____ Qty: _____ Refills: _____
<input type="checkbox"/> <b>Omnitrope®</b> <input type="checkbox"/> 1.5 mg vials w/ diluent (supplies needed) <input type="checkbox"/> 5.8 mg vials w/ diluent (supplies needed) <input type="checkbox"/> 1 mL syringe <input type="checkbox"/> _____ mL syringe Sig: _____ Qty: _____ Refills: _____	<input type="checkbox"/> <b>Saizen®</b> for GHD (subQ or IM inj) <input type="checkbox"/> 5 mg vial w/10 mL vial of sterile water for inj. <input type="checkbox"/> 8.8 mg vial w/10 mL vial of sterile water for inj. <input type="checkbox"/> BD ultra-fine 29 g 1/2" pen needles <input type="checkbox"/> Click easy recond. device w/ Saizen 8.8 mg <input type="checkbox"/> Reconstitution diluent vol Sig: _____ Qty: _____ Refills: _____
<input type="checkbox"/> <b>Genotropin®</b> (subQ inj) <input type="checkbox"/> 5 mg pen needles <input type="checkbox"/> 29 g <input type="checkbox"/> 30 g <input type="checkbox"/> 31 g <input type="checkbox"/> 12 mg pen needles <input type="checkbox"/> 29 g <input type="checkbox"/> 30 g <input type="checkbox"/> 31 g Sig: _____ Qty: _____ Refills: _____	If you would like brand names, please write " <i>Brand Medically Necessary</i> ". Please note Kerr Health Specialty Pharmacy will dispense our formulary product unless otherwise specified.
<input type="checkbox"/> <b>Tev-Tropin®</b> for GHD (subQ inj) <input type="checkbox"/> 5 mg vials plus 5 mL diluent vial <input type="checkbox"/> Injection syringes <input type="checkbox"/> .3 cc <input type="checkbox"/> .5 cc <input type="checkbox"/> 1 cc <input type="checkbox"/> Reconstitution syringes <input type="checkbox"/> 1 cc <input type="checkbox"/> 3 cc <input type="checkbox"/> BD ultra-fine needle <input type="checkbox"/> 29 g <input type="checkbox"/> 30 g <input type="checkbox"/> 31 <input type="checkbox"/> 32 g Sig: _____ Refills: _____	

### NOTES

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I authorize Kerr Health Specialty Pharmacy and its representatives to act as my agents for prior authorization and prescription processing for this patient.

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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