



SPECIALTY PHARMACY

# GROWTH HORMONE

Lake Mary, FL toll free

toll free fax

krogerspecialtypharmacy.com

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO: ☐ PATIENT ☐ OFFICE ☐ OTHER \_\_\_\_\_

PATIENT INFO		PRESCRIBER INFO	
Patient Name		Prescriber Name	
Address		DEA # NPI # License #	
City, State, Zip		Address	
Main Phone Alternate Phone		City, State, Zip	
Social Security #		Phone Fax	
Date of Birth <input type="checkbox"/> Male <input type="checkbox"/> Female		Contact Person	

**INSURANCE:** PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

\*\* Diagnosis confirmed with appropriate lab testing and available upon request if insurance requires it

Drug Allergies: \_\_\_\_\_

☐ Epiphysis open: ☐ Yes ☐ No Bone Age: \_\_\_\_\_ Growth Velocity: \_\_\_\_\_ Stim #1: / / ☐ Pass ☐ Fail

Patent Weight: \_\_\_\_\_ kg Patent Height: \_\_\_\_\_ Stim #1: / / ☐ Pass ☐ Fail

MED.	DOSE/STRENGTH	SIG	QTY	RF
<input type="checkbox"/> Genotropin*	<input type="checkbox"/> cartridge: <input type="checkbox"/> 5mg <input type="checkbox"/> 12mg <input type="checkbox"/> mini-quick*: <input type="checkbox"/> 0.2mg <input type="checkbox"/> 0.4mg <input type="checkbox"/> 0.6mg <input type="checkbox"/> 0.8mg <input type="checkbox"/> 1.0mg <input type="checkbox"/> 1.2mg <input type="checkbox"/> 1.4mg <input type="checkbox"/> 1.6mg <input type="checkbox"/> 1.8mg <input type="checkbox"/> 2mg		1 month	
<input type="checkbox"/> Humatrope*	<input type="checkbox"/> cartridge: <input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg <input type="checkbox"/> vial: 5mg		1 month	
<input type="checkbox"/> Norditropin*	<input type="checkbox"/> FlexPro*: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg		1 month	
<input type="checkbox"/> Nutropin* AQ	<input type="checkbox"/> NuSpin* Pen: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg <input type="checkbox"/> cartridge: <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg		1 month	
<input type="checkbox"/> Omnitrope*	<input type="checkbox"/> cartridge: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> vial: 5.8mg		1 month	
<input type="checkbox"/> Saizen*	<input type="checkbox"/> vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg <input type="checkbox"/> Click-Easy*: 8.8mg		1 month	

SUPPLIES ☐ Pen Needles Size \_\_\_\_\_ Qty \_\_\_\_\_ ☐ Syringes Size \_\_\_\_\_ Qty \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and it's employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) Dispense As Written Date Prescriber's Signature (no stamps) Substitution Permitted Date

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