



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	

PLEASE FAX COPY OF: ☐ PRESCRIPTION CARD FRONT & BACK ☐ CLINICAL NOTES ☐ 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 ☐ FailPatient Weight: \_\_\_\_\_ kg Patient Height: \_\_\_\_\_ Stim #2: / / ☐ 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"/> 1mg <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 Dilute vial with _____ mL/diluent		1 month	_____
<input type="checkbox"/> Norditropin*	FlexPro*: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg		1 month	_____
<input type="checkbox"/> Nutropin* AQ	NuSpin* Pen: <input type="checkbox"/> 5mg <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 Dilute vial with _____ mL/diluent <input type="checkbox"/> Click-Easy*: 8.8mg <input type="checkbox"/> Saizenprep*: 8.8mg		1 month	_____
<input type="checkbox"/> Supprelin LA*	implant: 50mg		12 month	_____
<input type="checkbox"/> Zomacton*	vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg Dilute vial with _____ mL/diluent		1 month	_____
<input type="checkbox"/> Other			_____	_____

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