# Growth Hormone Enrollment Form

**Fax Referral To:** 1-888-280-1191 OR 787-759-4161
**Phone:** 1-888-280-1190 OR 787-759-4162
**Email Referral To:** Customer.ServiceFax@CVSHealth.com
**Address:** 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927

## Six Simple Steps to Submitting a Referral

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

Patient Name: _____ DOB: _____
Address: _____City, State, ZIP Code: _____
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*
Primary Phone: _____ Alternate Phone: _____
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): _____
**Relationship to minor**: _____
Email: _____ Last Four of SSN: _____ Primary Language: _____

### 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: _____ Height: _____in/cm Weight: _____lb/kg

**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

 

# Growth Hormone Enrollment Form

**Please Complete Patient and Prescriber Information**

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

## 5 PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DOSE & DIRECTIONS | QUANTITY/REFILLS |
|---|---|---|---|
| ☐ Genotropin<br><br>Note: Prescriber must order pen/device from manufacturer | ☐ 5 mg pen cartridge<br>☐ 12 mg pen cartridge<br>☐ 0.2 mg MiniQuick ☐ 0.4 mg MiniQuick<br>☐ 0.6 mg MiniQuick ☐ 0.8 mg MiniQuick<br>☐ 1.0 mg MiniQuick ☐ 1.4 mg MiniQuick<br>☐ 1.6 mg MiniQuick ☐ 1.8 mg MiniQuick<br>☐ 2.0 mg MiniQuick | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ Humatrope | ☐ 6 mg cartridge kit<br>☐ 12 mg cartridge kit<br>☐ 24 mg cartridge kit | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ HumatroPen | ☐ 6 mg ☐ 12 mg<br>☐ 24 mg | Use as directed with Humatrope cartridge | Quantity:_____ |
| ☐ Increlex | 40 mg/4 mL vial | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ Norditropin FlexPro | ☐ 5 mg ☐ 10 mg<br>☐ 15 mg ☐ 30 mg | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ Nutropin AQ Nuspin | ☐ 5 mg ☐ 10 mg ☐ 20 mg | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ Omnitrope<br><br>Note: Prescriber must order pen/device from manufacturer | ☐ 5 mg/1.5 mL cartridges<br>☐ 10 mg/1.5 mL cartridges<br>☐ 5.8 mg/vial | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ Saizen<br><br>Note: Prescriber must order pen/device from manufacturer | ☐ 5 mg vial kit and diluent amount (1 mL – 3 mL): ____<br>☐ 8.8 mg vial kit and diluent amount (2 mL – 3 mL): ____<br>☐ 8.8 mg Saizenprep MDV | ____mg SC ____ days/week | Quantity:_____<br>Refills:_____ |
| ☐ Skytrofa<br><br>Note: Prescriber must order pen/device from manufacturer | ☐ 3 mg cartridges ☐ 3.6 mg cartridges<br>☐ 4.3 mg cartridges ☐ 5.2 mg cartridges<br>☐ 6.3 mg cartridges ☐ 7.6 mg cartridges<br>☐ 9.1 mg cartridges ☐ 11 mg cartridges<br>☐ 13.3 mg cartridges | ____mg SC once weekly | Quantity:_____<br>Refills:_____ |
| ☐ Zomacton | ☐ 5 mg vial and diluent amount (1 mL – 5 mL): ____<br>☐ 10 mg vial | ____mg SC ____ days/week | Quantity:_____<br>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<br>**Prescriber's Signature: _____Date: _____** | May Substitute / Product Selection Permitted / Substitution Permissible<br>**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.