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: _____Address: _____City, State, ZIP: _____
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: _____DOB: _____ Gender: ☐ Male ☐ Female
Email: _____Last Four of SSN: _____Primary Language: _____

2 PRESCRIBER INFORMATION

Prescriber's Name: _____ State License #: _____
NPI #: _____ DEA #: _____ Group or Hospital: _____
Address: _____ City, State, ZIP: _____
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

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Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

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:_____
☐ 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:_____
☐ Saizen Note: Prescriber must order pen/device from manufacturer	☐ 5 mg vial kit and diluent amount (1mL – 3mL): ____ ☐ 8.8 mg vial kit and diluent amount (2mL – 3mL): ____ ☐ 8.8 mg Saizenprep MDV	____mg SC ____ days/week	Quantity:_____ Refills:_____
☐ Skytrofa Note: Prescriber must order pen/device from manufacturer	☐ 3mg cartridges ☐ 3.6mg cartridges ☐ 4.3mg cartridges ☐ 5.2mg cartridges ☐ 6.3mg cartridges ☐ 7.6mg cartridges ☐ 9.1mg cartridges ☐ 11mg cartridges ☐ 13.3mg cartridges	____mg SC once weekly	Quantity:_____ Refills:_____
☐ Zomacton	☐ 5 mg vial and diluent amount (1mL – 5mL): ____ ☐ 10 mg vial	____mg SC ____ days/week	Quantity:_____ Refills:_____

I hereby freely and voluntarily have selected CVS Caremark and/or CarePlus CVS/pharmacy to dispense the medication herein prescribed by my physician.

Patient Signature:_____

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X_____ X_____

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.