Please fax both pages of completed form to your team at 888.355.6682.

To reach your team, call toll-free 877.218.0410.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Adult Growth Disorders

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Four simple steps to submit your referral.

1 Patient Information

Please attach copies of front and back of the patient's medical and prescription insurance cards.

❑ New patient ❑ Current patient

Patient's first name ____________ Last name ____________ Middle initial ______

❑ Male ❑ Female Last 4 digits of SSN ____________ Date of birth ____________

Street address ____________ Apt # ______

City ____________ State ____________ Zip ____________

Home phone ____________ Cell phone ____________ E-mail address ____________

Parent/guardian (if applicable) ____________

Home phone ____________ Cell phone ____________ E-mail address ____________

Alternate caregiver/contact ____________

Home phone ____________ Cell phone ____________ E-mail address ____________

❑ OK to leave message with alternate caregiver/contact

Patient's primary language: ❑ English ❑ Other If other, please specify ____________

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date ____________ Time ____________ Date medication needed ____________

Prescriber's first name ____________ Last name ____________

Prescriber's title ____________ If NP or PA, under direction of Dr. ____________

Office address ____________

Office contact and title ____________

Office contact phone number ____________ Office contact e-mail ____________

Office/Infusion clinic name ____________ Office/Infusion clinic affiliation ____________

Street address ____________ Suite # ______

City ____________ State ____________ Zip ____________

Phone ____________ Fax ____________ NPI # ____________ License # ____________

Deliver product to: ❑ Office ❑ Patient's home ❑ Clinic Clinic location: ____________

3 Clinical Information

Primary ICD-10 code: ____________ Weight (kg) ______ Height (cm) ______ Date measured ______

Injection training needed: ❑ Yes ❑ No By: ❑ MD office ❑ Other ____________

If prior HgH used, date started ____________

❑ NKDA ❑ Known drug allergies ____________

Concurrent meds ____________

Please attach the following information for growth disorder diagnosis: Drug profile, labs, growth chart where applicable

Patient's first name ______________________ Last name _________________________ Middle initial ______ Date of birth __________

Prescriber's first name ______________________________ Last name ________________________________ Phone _________________

4 Prescribing Information

Medication	Dose	Directions	Quantity/Refills
❑ Genotropin® (somatropin) cartridge	❑ 5mg ❑ 12mg		Dispense: ❑ 1-month supply ❑ 3-month supply ❑ Other ____________ ____________ ❑ Refills ____________
❑ Genotropin (somatropin) Mini Quick® (somatropin) cartridge	❑ 0.2mg ❑ 0.4mg ❑ 0.6mg ❑ 0.8mg ❑ 1mg ❑ 1.2mg ❑ 1.4mg ❑ 1.6mg ❑ 1.8mg ❑ 2mg		
❑ Humatrope® (somatropin) 5mg vial			
❑ Humatrope (somatropin) cartridge	❑ 6mg ❑ 12mg ❑ 24mg		
❑ HumatroPen® (somatropin) injection device for cartridge	❑ 6mg ❑ 12mg ❑ 24mg		
❑ Increlex® (mecasermin) 40mg/4mL vial			
❑ Norditropin® (somatropin) FlexPro® prefilled pen	❑ 5mg ❑ 10mg ❑ 15mg ❑ 30mg		
❑ Nutropin (somatropin) AQ Pen® cartridge 20mg/2mL			
❑ Nutropin (somatropin) AQ NuSpin® prefilled device	❑ 5mg ❑ 10mg ❑ 20mg	**Ancillary Supplies**	**Quantity/Refills**
❑ Omnitrope® (somatropin) 5.8mg vial		❑ Prescriber, please check here to authorize ancillary supplies such as needles, syringes, sterile water, etc. to administer the therapy as needed.	Send quantity sufficient for medication days supply
❑ Omnitrope (somatropin) cartridge	❑ 5mg/1.5mL ❑ 10mg/1.5mL		
❑ Saizen® (somatropin)	❑ 5mg vial ❑ 8.8mg vial ❑ 8.8mg cartridge		
❑ Zomacton® (somatropin)	❑ 5mg vial ❑ 10mg vial		
❑ Other ____ ____			

If shipped to physician's office or infusion clinic, physician accepts on behalf of patient for administration in office or infusion clinic.

I certify that this medication is not being prescribed for anti-aging, cosmetic or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.

Prescriber's signature (sign below) (Physician attests this is his/her legal signature. NO STAMPS)

PHYSICIAN SIGNATURE REQUIRED

SIGN HERE

________________ ________________________________ ________________ ________________________________

Date **Dispense as written** **Date** **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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COMMON DIAGNOSIS CODES

B20 Human immunodeficiency virus [HIV] disease

With: **R64** Cachexia (Serostim® only)

With: **E88.1** Lipodystrophy (Egrifta® only)

E23.0 Idiopathic growth hormone deficiency:

• Childhood-onset • Adult-onset

E34.3 Short stature due to endocrine disorder

E23.0 Acquired growth hormone deficiency with:

• Childhood-onset • Adult-onset

C75.1 Malignant neoplasm of pituitary gland

C75.2 Malignant neoplasm of craniopharyngeal duct

D35.2 Benign neoplasm of pituitary gland

D35.3 Benign neoplasm of craniopharyngeal duct

E23.0 Hypopituitarism

E23.1 Drug-induced hypopituitarism

E89.3 Postprocedural hypopituitarism

E23.3 Hypothalamic dysfunction

N18.9 Chronic kidney disease (child, pre-transplant):

• HD • CAPD • CCPD, schedule: ____________________

N18.2 CKD, Stage II (Mild)

N18.3 CKD, Stage III (Moderate)

N18.4 CKD, Stage IV (Severe)

N18.5 CKD, Stage V

N18.6 End stage renal disease

Congenital disease & associated disorders:

Q96.9 Turner's syndrome

Q87.1 Noonan syndrome

Q87.1 Prader-Willi syndrome

E34.3, Q78.8 SHOX deficiency

Q87.1 Russell-Silver syndrome

Q89.8 Other specified congenital malformations

R62.50 Severe IGF-1 deficiency (Increlex® only)

R62.52 Small for Gestational Age with inadequate catch-up growth (child):

P05.10 Small for gestational age

P05.00 Light for gestational age

P05.9 Slow intrauterine growth

R62.52 Idiopathic Short Stature (child) with – 2.25 SDS

K91.2 Short-bowel Syndrome (Zorbtive® only)