

Four simple steps to submit your referral.

1 PATIENT INFORMATION

New patient Current

Patient's name _____
 Date of birth _____ Male Female Last 4 digits of SSN _____
 Street address _____ Apt # _____
 City _____ State _____ Zip _____
 Parent/guardian (if applicable) _____
 Home phone _____ Work phone _____ Cell phone _____
 Evening phone _____ E-mail address _____
 Patient's primary language: English Other If other, please specify _____

Please attach front and back of patient's insurance cards or complete information below.

Insurance company _____ Phone _____
 Insured's name _____
 Insured's employer _____ Relationship to patient _____
 Identification # _____ Policy/group # _____
 Prescription card: Yes No If yes, carrier _____
 Policy # _____ Group # _____
 Is patient eligible for Medicare? Yes No Does patient have a secondary insurance? Yes No

2 PRESCRIBER INFORMATION

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____
 Prescriber's name and title _____
 If NP or PA, under direction of Dr. _____
 Office contact _____
 Clinic/hospital 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 use, date started _____
 NKDA Known drug allergies _____
 Concurrent meds _____

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

Please fax completed form to the Growth Disorder team 888.355.6682.

To reach your team, call toll-free 877.218.0410.

4 PRESCRIBING INFORMATION

Medication	Directions	Quantity/Refills
<input type="checkbox"/> Genotropin® (somatropin) cartridge <input type="checkbox"/> 5 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> Genotropin (somatropin) Mini Quick® prefilled syringe <input type="checkbox"/> 0.2 mg <input type="checkbox"/> 0.4 mg <input type="checkbox"/> 0.6 mg <input type="checkbox"/> 0.8 mg <input type="checkbox"/> 1 mg <input type="checkbox"/> 1.2 mg <input type="checkbox"/> 1.4 mg <input type="checkbox"/> 1.6 mg <input type="checkbox"/> 1.8 mg <input type="checkbox"/> 2 mg <input type="checkbox"/> Humatrope® (somatropin) 5 mg vial <input type="checkbox"/> Humatrope (somatropin) cartridge <input type="checkbox"/> 6 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> 24 mg <input type="checkbox"/> HumatroPen® (somatropin) injection device for cartridge <input type="checkbox"/> 6 mg <input type="checkbox"/> 12 mg <input type="checkbox"/> 24 mg <input type="checkbox"/> Increlex® (mecasermin) 40 mg/4 mL vial <input type="checkbox"/> Norditropin® (somatropin) FlexPro® prefilled pen <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 15 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> Nutropin (somatropin) AQ Pen® cartridge 20 mg/2 mL <input type="checkbox"/> Nutropin (somatropin) AQ NuSpin® prefilled device <input type="checkbox"/> 5 mg <input type="checkbox"/> 10 mg <input type="checkbox"/> 20 mg <input type="checkbox"/> Omnitrope® (somatropin) 5.8 mg vial <input type="checkbox"/> Omnitrope (somatropin) cartridge <input type="checkbox"/> 5 mg/1.5 mL <input type="checkbox"/> 10 mg/1.5 mL <input type="checkbox"/> Saizen® (somatropin) <input type="checkbox"/> 5 mg vial <input type="checkbox"/> 8.8 mg vial <input type="checkbox"/> 8.8 mg cartridge <input type="checkbox"/> Zomacton® (somatropin) <input type="checkbox"/> 5 mg vial <input type="checkbox"/> 10 mg vial <input type="checkbox"/> Other _____		Dispense: <input type="checkbox"/> 1-month supply <input type="checkbox"/> 3-month supply <input type="checkbox"/> Other _____ Refills _____
	Ancillary Supplies	Quantity/Refills
	<input type="checkbox"/> 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

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

By signing below, I certify that the above therapy is medically necessary.

I authorize HUB to act on my behalf for the limited purposes of transmitting this prescription to the appropriate pharmacy designated by the patient utilizing their benefit plan.

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

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.

THIS AREA INTENTIONALLY LEFT BLANK.

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)