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accredo.com

**RESET FORM**

**Facsimile Transmittal**

Date \_\_\_\_\_

Attention \_\_\_\_\_

Regarding patient \_\_\_\_\_

Federal law (21 U.S.C. § 333 (e) (1)) limits distribution of growth hormone to the treatment of disease or other recognized medical conditions approved by the FDA. Accordingly, Accredo Specialty Pharmacy will not dispense human growth hormone for anti-aging, cosmetic or performance enhancement purposes, or for any other use (medical or non-medical) that has not been approved by the FDA.

A statement of medical necessity (SMN) that includes the drug name, diagnosis and prescriber's signature is required by Accredo for growth hormone dispensing. In absence of an SMN, please complete the attached Growth Hormone Certification expeditiously to prevent a possible delay to your patient's therapy:

1. Please fill out the form in its **entirety**.
2. Supervising physician signing the form must indicate the physician who they are signing for or are assigned to.
3. Stamped signatures are not permitted.

**NOTE:** An SMN or Accredo Growth Hormone Certification form is only required once for each patient receiving therapy at the onset of therapy. A new form will only be required if the Prescriber changes or growth hormone indication changes.

Thank you,

Accredo

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The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

**Prescriber Certification for Human Growth Hormone Indication**

Patient name (Last, First) \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Gender: M  F  Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Human Growth Hormone Medication Prescribed \_\_\_\_\_

**Accredo does not dispense human growth hormone for anti-aging, cosmetic or performance enhancement purposes, pursuant to 21 U.S.C. § 333 (e)(1), which limits usage only to the treatment of disease or other recognized medical conditions authorized by the Secretary of Health and Human Services.**

Common diagnosis codes are listed below for your convenience.

Please check all that apply below or list your patient's primary indication and diagnosis coding for growth hormone therapy below:

**COMMON DIAGNOSIS CODES**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>B20</b> Human immunodeficiency virus [HIV] disease               <ul style="list-style-type: none"> <li>With: <b>R64</b> Cachexia (Serostim<sup>®</sup> only)</li> <li>With: <b>E88.1</b> Lipodystrophy (Egrifta<sup>®</sup> only)</li> </ul> </li> <li><input type="checkbox"/> <b>E23.0</b> Idiopathic growth hormone deficiency:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Childhood-onset    <input type="checkbox"/> Adult-onset</li> <li><input type="checkbox"/> <b>E34.3</b> Short stature due to endocrine disorder</li> </ul> </li> <li><input type="checkbox"/> <b>E23.0</b> Acquired growth hormone deficiency with:               <ul style="list-style-type: none"> <li><input type="checkbox"/> Childhood-onset    <input type="checkbox"/> Adult-onset</li> <li><input type="checkbox"/> <b>C75.1</b> Malignant neoplasm of pituitary gland</li> <li><input type="checkbox"/> <b>C75.2</b> Malignant neoplasm of craniopharyngeal duct</li> <li><input type="checkbox"/> <b>D35.2</b> Benign neoplasm of pituitary gland</li> <li><input type="checkbox"/> <b>D35.3</b> Benign neoplasm of craniopharyngeal duct</li> <li><input type="checkbox"/> <b>E23.0</b> Hypopituitarism</li> <li><input type="checkbox"/> <b>E23.1</b> Drug-induced hypopituitarism</li> <li><input type="checkbox"/> <b>E89.3</b> Postprocedural hypopituitarism</li> <li><input type="checkbox"/> <b>E23.3</b> Hypothalamic dysfunction</li> </ul> </li> <li><input type="checkbox"/> <b>N18.9</b> Chronic kidney disease (child, pre-transplant):</li> <li><input type="checkbox"/> HD    <input type="checkbox"/> CAPD    <input type="checkbox"/> CCPD, schedule: _____               <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>N18.2</b> CKD, Stage II (Mild)</li> <li><input type="checkbox"/> <b>N18.3</b> CKD, Stage III (Moderate)</li> <li><input type="checkbox"/> <b>N18.4</b> CKD, Stage IV (Severe)</li> <li><input type="checkbox"/> <b>N18.5</b> CKD, Stage V</li> <li><input type="checkbox"/> <b>N18.6</b> End stage renal disease</li> </ul> </li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Congenital disease &amp; associated disorders:</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Q96.9</b> Turner's syndrome</li> <li><input type="checkbox"/> <b>Q87.1</b> Noonan syndrome</li> <li><input type="checkbox"/> <b>Q87.1</b> Prader-Willi syndrome</li> <li><input type="checkbox"/> <b>E34.3, Q78.8</b> SHOX deficiency</li> <li><input type="checkbox"/> <b>Q87.1</b> Russell-Silver syndrome</li> <li><input type="checkbox"/> <b>Q89.8</b> Other specified congenital malformations</li> </ul> </li> <li><input type="checkbox"/> <b>R62.50</b> Severe IGF-1 deficiency (Increlex<sup>®</sup> only)</li> <li><input type="checkbox"/> <b>R62.52</b> Small for Gestational Age with inadequate catch-up growth (child):               <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>P05.10</b> Small for gestational age</li> <li><input type="checkbox"/> <b>P05.00</b> Light for gestational age</li> <li><input type="checkbox"/> <b>P05.9</b> Slow intrauterine growth</li> </ul> </li> <li><input type="checkbox"/> <b>R62.52</b> Idiopathic Short Stature (child) with – 2.25 SDS</li> <li><input type="checkbox"/> <b>K91.2</b> Short-bowel Syndrome (Zorbtive<sup>®</sup> only)</li> <li><input type="checkbox"/> Other (ICD-10 required): _____</li> </ul> |
|--|---|

**Prescriber Certification:**

**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 signature \_\_\_\_\_ Date \_\_\_\_\_

Print prescriber name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Please fax completed form to Accredo Growth Disorder Pharmacy Team at 888.355.6682.**

Pharmacy Use Only:

Reviewed and Approved \_\_\_\_\_ RPh Rx# \_\_\_\_\_ Date \_\_\_\_\_