accredo®
Specialty Pharmacy

1620 Century Center Parkway
Memphis, TN 38134
Ph: 877.218.0410, option 3
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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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

❑ **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)

❑ Other (ICD-10 required): _____
_____

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 _____

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