Pharmaceutical Specialties, Inc.
Family owned, patient focused.

Phone: 800-818-6486 ◆ Fax: 800-818-6490

Prescription Form – Growth Hormone

Patient: _____ DOB: _____ DX: _____

Address: _____ Height: _____ Weight: _____

☐ Norditropin FlexPro® 15mg (dose in 0.1mg increments; Max dose 8.0mg) _____mg SQ _____days/week
☐ Norditropin FlexPro® 10mg (dose in 0.05mg increments; Max dose 4.0mg)
☐ Norditropin FlexPro® 5mg (dose in 0.025mg increments; Max dose 2.0mg)
☐ Norditropin FlexPro® 30mg (dose in 0.1 mg increments; Max dose 8.0mg)

☐ Saizen® vials ☐ 8.8mg ☐ 5mg Add _____cc and inject_____cc (_____mg) SQ _____days/week
Use with: ☐ cool.click™2 ☐ Insulin Syringes
☐ Saizen® click.easy® 8.8mg for one.click® device (0.12mg per click) Administer _____mg (_____clicks) SQ _____days/week
☐ easypod® using Saizen® 8.8mg Cartridges (Min dose 0.15mg/Max 4.6mg) Administer _____mg SQ _____days/week
Dose adjustment (check one): ☐ Off ☐ Greater than 50% -OR- Automatic dose adjustment: ☐ 10% ☐ 25% ☐ 50%

☐ Humatrope® 24mg/3cc cartridges (dose in 0.1 mg increments: Max dose 6.0 mg) _____mg SQ _____days/week
☐ Humatrope® 12mg/3cc cartridges (dose in 0.05 mg increments: Max dose 3.0 mg)
☐ Humatrope® 6mg/3cc cartridges (dose in 0.025mg increments: Max dose 1.5 mg)
☐ Humatrope® 5mg powder vials Add _____cc and inject_____cc (_____mg) SQ _____days/week

☐ Genotropin 12mg cartridges (dose in 0.2mg increments; Max dose 4.0mg) _____mg SQ _____days/week
☐ Genotropin 5mg cartridges (dose in 0.1mg increments; Max dose 2.0mg)
☐ PEN® 5 ☐ PEN® 12 ☐ MIXER® & Insulin Syringes
☐ Genotropin MINIQUICK® Syringes (dose in 0.2mg increments; Preservative Free)
☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg

☐ Other: _____ Administer: _____
☐ Other: _____ Administer: _____

Dispense above RX with all necessary supplies for administration: Pen Needle Size (check one) ☐ 29 ☐ 30 ☐ 31 ☐ 32

Disp _____ ***month(s) supply*** ***Refills:*** _____ **Prn x 1 year** **or** _____ **months total**

Provider Name: _____ NPI: _____ DEA: _____ License #: _____
Practice Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Office Contact: _____ Phone: _____ Fax: _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____

www.psipharmacy.com

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Growth Hormone Statement of Medical Necessity

Patient's Name: _____ DOB: _____ ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Parent / Primary Contact: _____ Relationship: _____

SS#: _____ Home Phone: _____ Work Phone: _____

☐ **See Insurance Information attached** ☐ **No Insurance**

Insurance Company: _____ Policyholder's Name: _____

Policyholder's Member ID: _____ Policyholder's Group #: _____

Insurance Co. Phone#: _____ Employer: _____

☐ Panhypopituitarism (253.2) (ICD10-E23.0) ☐ Isolated GH Deficiency (253.3) ICD10-E23.0) ☐ Iatrogenic Hypopituitarism (253.7)

☐ Other Pituitary Disorders (253.8) (ICD10-E23.0) ☐ Pituitary Tumor (227.3) ☐ Craniopharyngioma/Pit. Neoplasm (237.0)

☐ Short Stature/Growth failure (783.43) ☐ Turner Syndrome (758.6) ☐ Prader-Willi Syndrome (759.81)

☐ Chronic Kidney Disease (585.___) ☐ SGA (764.00) or ☐ (764.90) ☐ Noonan Syndrome (759.89)

☐ SHOX Deficiency (ICD10-E34.3) ☐ Other/(ICD-9): _____

Height: _____ cm _____ % SDS (if ISS): _____ Agent: _____ Peak Value: _____

Weight: _____ kg _____ % Growth Velocity: _____ cm/yr Agent: _____ Peak Value: _____

Bone Age: _____ yrs _____ mo Date of X-Ray: _____ GH Stimulation Test Date: _____

IGF-1: _____ IGFBP-3: _____ Imaging: _____

☐ **Growth Chart Attached** ☐ **Clinical Notes Attached** ☐ **Laboratory Results Attached**

Dose: _____ mg/inj (_____ ml) **SubQ**: _____ inj/week **Dispense**: _____ mo **Refill** X _____ or _____ **PRN**

OTHER RELEVANT INFORMATION: _____

_____

_____

Preferred Distributor: ☐ Pharmaceutical Specialties, Inc. ☐ Other: _____

☐ *I certify that the growth hormone therapy described is medically necessary and the patient information provided is accurate and to the best of my knowledge. I have obtained the patients affirmative authorization to release reference information and medical and/or other patient information relating to growth hormone therapy as deemed necessary.*

Provider Name: _____ NPI: _____ DEA: _____ License #: _____

Practice Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Office Contact: _____ Phone: _____ Fax: _____

PRESCRIBER SIGNATURE: _____ **DATE:** _____