



Pediatric GH Prescription

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 NordiFlex® 30mg (dose in 0.1 mg increments; Max dose 6.0mg)

- 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

- NuSpin Pen 20® 20mg (dose in 0.2mg increments; Max dose 7.0mg) _____mg SQ _____days/week
- NuSpin Pen 10® 10mg (dose in 0.1mg increments; Max dose 3.5mg)
- NuSpin Pen 5® 5mg (dose in 0.5mg increments; Max dose 1.75mg)
- Nutropin AQ® Pen Cartridge 20mg/2cc (dose in 0.2mg increments; Max dose 8.0mg)
- Nutropin AQ® Pen Cartridge 10mg/2cc (dose in 0.1mg increments; Max dose 4.0mg)
- Nutropin AQ® Vial 10mg/2cc vials (5mg/cc)
- Nutropin® Powder vials 5mg 10mg Add _____cc and inject _____cc (____mg) SQ _____days/week

- Tev-Tropin® 5mg Vials Tjet® OR Insulin Syringes Add _____cc and inject _____cc (____mg) SQ _____days/week
- 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

- 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

Physician's Signature

Print Physician Name

Date Written

Address

City

State

Zip

Phone and Fax

DEA#

NPI#



GH 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.

Physician's Signature

Print Physician Name

Date Written

Address

City

State

Zip

Phone and Fax

DEA#

NPI#



Pharmaceutical Specialties, Inc.

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



Patient Resources

You will be contacted by Pharmaceutical Specialties, Inc. (PSI) promptly regarding your prescription. Please call the number above at anytime if you have questions.

PSI Pharmacy has more than 30 years of experience caring for patients with complex medical conditions. PSI provides these benefits for you:

- ❖ Free Sharps disposal by mail system
- ❖ Benefits and financial assistance coordination
- ❖ Medication delivered at no extra charge
- ❖ On call pharmacist 24/7 for questions and patient counseling
- ❖ Nursing education if requested by your provider
- ❖ Referrals to local support and advocacy organizations
- ❖ Additional prescription medications as needed

NOTE: Refrigerate injectable medication upon receipt.

For additional support during your therapy, we recommend that you reference the appropriate support organization listed below.

NOVO NORDISK:

NordiCare®
888-668-6444
www.norditropin-us.com

GENENTECH:

Nutropin® Access Solutions
866-Nutropin (866-688-7674)
www.nutropinaccesssolutions.com

PFIZER:

Bridge Program
800-645-1280
www.genotropin.com

LILLY:

Humatrope® Reimbursement
800-642-2340
www.humatrope.com

SERONO:

Saizen® Connections for Growth
800-582-7989
www.saizen-us.com

TEVA:

Growth Solutions
866-838-8767
www.tev-tropin.com

Helpful websites for more information:

Magic Foundation
www.magicfoundation.org
800-362-4423

Human Growth Foundation
www.hgfound.org
800-451-6434