



Phone: 1-888-315-3395
Fax: 1-888-315-3270

Growth Hormone Referral Form

Attn: _____

Today's Date: _____

Date Shipment Needed: _____

Ship To: Patient Physician

Nurse Instruction Needed? Yes No

Agency: _____

Permission to contact pt: Yes No

* All the supplies including syringes and needles will be dispensed if needed.

General Information

Patient Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Work Phone: _____ Cell Phone: _____ Soc. Sec #: _____ - _____ - _____ Date of Birth: _____ Allergies: _____ Current Meds: _____ Weight: _____ Height: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Physician Name: _____ Practice Name/Hospital: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____ State Lic #: _____ DEA #: _____ NPI #: _____ Nurse/Key Office Contact: _____
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Insurance Information

Primary Insurance: _____ Employer: _____ Phone: _____	Cardholder Name: _____ ID#: _____ Group#: _____	Secondary Insurance: _____ ID#: _____ Group#: _____ Phone: _____
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Prescription

<input type="checkbox"/> Genotropin	Powder	<input type="checkbox"/> 12mg <input type="checkbox"/> 5mg
	Miniquick	<input type="checkbox"/> 0.2mg <input type="checkbox"/> 0.4mg <input type="checkbox"/> 0.6mg <input type="checkbox"/> 0.8mg <input type="checkbox"/> 1mg <input type="checkbox"/> 1.2mg <input type="checkbox"/> 1.4mg <input type="checkbox"/> 1.6mg <input type="checkbox"/> 1.8mg <input type="checkbox"/> 2mg
<input type="checkbox"/> Humatrope	Cartridge	<input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg
	Powder	<input type="checkbox"/> 5mg
<input type="checkbox"/> Norditropin	Cartridge	<input type="checkbox"/> 5mg/1.5ml <input type="checkbox"/> 15mg/1.5ml
	FlexPro Pen	<input type="checkbox"/> 5mg/1.5ml <input type="checkbox"/> 10mg/1.5ml <input type="checkbox"/> 15mg/1.5ml
	Nordiflex Pen	<input type="checkbox"/> 5mg/1.5ml <input type="checkbox"/> 10mg/1.5ml <input type="checkbox"/> 15mg/1.5mL <input type="checkbox"/> 30mg/3ml
<input type="checkbox"/> Nutropin	Powder	<input type="checkbox"/> 5mg <input type="checkbox"/> 10mg
	Solution	<input type="checkbox"/> 10mg/2ml
<input type="checkbox"/> Nutropin AQ	Pen	<input type="checkbox"/> 10mg/2ml <input type="checkbox"/> 20mg/2ml
	NuSpin	<input type="checkbox"/> 5mg/2ml Cartridge <input type="checkbox"/> 10 Pen <input type="checkbox"/> 20 Pen
	Powder	<input type="checkbox"/> 5.8mg
<input type="checkbox"/> Omnitrope	Solution	<input type="checkbox"/> 5mg/1.5ml <input type="checkbox"/> 10mg/1.5ml
	Powder	<input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg
<input type="checkbox"/> Saizen	Powder	<input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg
	Click.Easy	<input type="checkbox"/> 8.8mg
<input type="checkbox"/> Serostim	Powder	<input type="checkbox"/> 4mg <input type="checkbox"/> 5mg <input type="checkbox"/> 6mg <input type="checkbox"/> 8.8mg
<input type="checkbox"/> Somavert	Powder	<input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 20mg
<input type="checkbox"/> Tev-Tropin	Powder	5mg
<input type="checkbox"/> Zorbtive	Powder	8.8mg

Statement of Medical Necessity

Primary Diagnosis:

253.2 Panhypopituitarism

585 Chronic Renal Failure

758.6 Turner Syndrome

253.3 Pituitary Dwarfism/Isolated GHD

253.7 Iatrogenic-induced Hypopituitarism

783.43 Short Stature

783.43 + 764.90 IUGR, unspec.

783.43 + 764.0 Small for Dates

759.81 Prader-Willi Syndrome

253.2 Adult GHD

569.9 Short Bowel Syndrome

Other:

* Diagnosis confirmed with appropriate lab testing and available upon request

Epiphysis open:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone Age:	
Growth Velocity:	
Stim #1: / /	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Stim #2: / /	<input type="checkbox"/> Pass <input type="checkbox"/> Fail

Supplies:

Pen Tips: 29G 30G 31G

* Preferred MIXING syringe/needle _____ (#_____)

* Preferred INJECTION syringe/needle _____ (#_____)

SIG: Inject _____mg SQ daily (____ days/week)
 Mix with _____mL of diluent.
 Withdraw & inject _____mg (____mL) SQ daily, ____days/week.

QTY: 1 month
REFILLS: _____

*If you would like brand name, please write Medically Necessary. Please note that Axiom will dispense our formulary product unless otherwise specified.

Physician Signature: _____ **Date:** _____