



Phone: 1-888-315-3395  
Fax: 1-800-546-2172



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.

## Growth Hormone Authorization Form

### 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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### Statement of Medical Necessity

Diagnosis w/ICD 9: _____ Diagnosis: _____ ICD 9: _____ Epiphysis open: Y / N Bone Age: _____	Growth Velocity: _____ Stim Test #1/date/Pass or Fail: _____ Stim Test #2/date/Pass or Fail: _____
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### Prescription Information

<b>Nutropin® (sq inj) 28d</b> <input type="checkbox"/> 5mg Vial w/10ml vial of Sterile Water for Inj. <input type="checkbox"/> 10mg Vial w/10ml vial of Sterile Water for Inj. <input type="checkbox"/> BD Ultra-Fine™ Pen Needles – 29g 12.7mm <input type="checkbox"/> Injection syringes <input type="checkbox"/> 0.3cc <input type="checkbox"/> 0.5cc <input type="checkbox"/> 1cc <input type="checkbox"/> Reconstitution syringes <input type="checkbox"/> 1cc <input type="checkbox"/> 3cc <input type="checkbox"/> Other: _____ Sig: _____ Refills _____	<b>Nutropin AQ® (sq inj) 28d</b> <input type="checkbox"/> 10mg Vial <input type="checkbox"/> 10mg/2ml Nutropin AQ Pen Cartridge <input type="checkbox"/> Nutropin AQ Pen <input type="checkbox"/> Nutropin AQ Pen Kit <input type="checkbox"/> BD Ultra-Fine™ Pen Needles – 29g 12.7mm <input type="checkbox"/> Injection syringes <input type="checkbox"/> 0.3cc <input type="checkbox"/> 0.5cc <input type="checkbox"/> 1cc <input type="checkbox"/> Other: _____ Sig: _____ Refills _____	<b>Saizen® for GHD (sq or IM inj) 14d</b> <input type="checkbox"/> 5mg vial w/10ml vial of sterile water for inj. <input type="checkbox"/> 8.8mg vial w/10ml vial of sterile water for inj. <input type="checkbox"/> BD ultra-fine 29g ½" pen needles <input type="checkbox"/> click.easy recon.device w/ Saizen 8.8mg <input type="checkbox"/> Reconstitution diluent vol _____ Sig: _____ # of Refills _____ Store at room temp before reconstituting
<b>Humatrope® (sq inj)</b> <input type="checkbox"/> 5mg vials (supplies are needed) <input type="checkbox"/> 6mg cartridge kit with 3ml diluent (2mg/ml) <input type="checkbox"/> 12mg cartridge kit with 3ml diluent (4mg/ml) <input type="checkbox"/> 24mg cartridge kit with 3ml diluent (8mg/ml) <input type="checkbox"/> HumatroPen® Sig: _____ sq QD/ _____ Refills _____	<b>Increlex® (40mg/4ml vials)</b> <input type="checkbox"/> Needle size _____ <input type="checkbox"/> Insulin syringe with needle attached Sig: _____ sq BID/ _____ wk Refills _____	<b>Genotropin® (sq inj)</b> <input type="checkbox"/> 5.8mg pen Pen needles <input type="checkbox"/> 29g <input type="checkbox"/> 30g <input type="checkbox"/> 31g <input type="checkbox"/> 13.8mg pen Pen needles <input type="checkbox"/> 29g <input type="checkbox"/> 30g <input type="checkbox"/> 31g Sig: _____ sq QD/ _____ <input type="checkbox"/> Miniquicks _____ mg QD Refills: _____
<b>Omnitrope®</b> <input type="checkbox"/> 5mg/1.5ml Cartridge <input type="checkbox"/> 10mg/1.5ml Cartridge <input type="checkbox"/> 5.8mg Vials w/diluent – supplies needed <input type="checkbox"/> Needle size _____ <input type="checkbox"/> Insulin syringe with needle attached Sig: _____ sq QD/ _____ wk Refills _____	<b>Tev-Tropin® for GHD (sq inj) 14d</b> <input type="checkbox"/> 5mg Vials plus 5ml diluent vial <input type="checkbox"/> Injection syringes <input type="checkbox"/> 0.3cc <input type="checkbox"/> 0.5cc <input type="checkbox"/> 1cc <input type="checkbox"/> Reconstitution syringes <input type="checkbox"/> 1cc <input type="checkbox"/> 3cc <input type="checkbox"/> BD ultra-fine needle <input type="checkbox"/> 29g <input type="checkbox"/> 30g <input type="checkbox"/> 31g <input type="checkbox"/> 32g Sig: _____ Refills _____	<b>Primary Diagnosis:</b> <input type="checkbox"/> 253.2 Panhypopituitarism <input type="checkbox"/> 585 Chronic Renal Failure <input type="checkbox"/> 758.6 Turner Syndrome <input type="checkbox"/> 253.3 Pituitary Dwarfism/Isolated Growth Hormone Deficiency <input type="checkbox"/> 253.7 Iatrogenic-induced Hypopituitarism <input type="checkbox"/> 783.43 Short Stature <input type="checkbox"/> 783.43 + 764.90 IUGR, unspc. <input type="checkbox"/> 783.43 + 764.0 Small for Dates <input type="checkbox"/> 759.81 Prader-Willi Syndrome <input type="checkbox"/> 253.2 Adult GHD <input type="checkbox"/> 569.9 Short Bowel Syndrome * Diagnosis confirmed with appropriate lab testing and available upon request
<b>Norditropin®</b> <input type="checkbox"/> NordiFlex® multidose disp. pen <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 5mg/1.5ml cart w/NordiPen® <input type="checkbox"/> 31g 6mm needle <input type="checkbox"/> 10mg/1.5ml <input type="checkbox"/> 15mg/1.5ml cart w/NordiPen® <input type="checkbox"/> 30g 8mm needle <input type="checkbox"/> NordiPenMate® - to hide the needle Sig: _____ sq QD/ _____ 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:** \_\_\_\_\_

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