

**ADULT AND PEDIATRIC ENDOCRINE**  
**TELEPHONE 1-800-237-2767 FAX 1-800-323-2445**

**1. PATIENT INFORMATION** *To be completed by the patient*

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	
Day Telephone # (+Area Code)		Night Telephone # (+Area Code)	Mobile Telephone # (+Area Code)	
Date of Birth (MM/DD/YYYY)		Social Security #	Sex (Check One) <input type="checkbox"/> M <input type="checkbox"/> F	
Parent/Guardian Name				

**INSURANCE INFORMATION**

Primary/Medical Insurance	Secondary/Pharmacy Insurance
Cardholder Name & ID # (If Not Patient)	Cardholder Name & ID # (If Not Patient)
Group/Policy #	Group/Policy #
Insurance Telephone # (+Area Code)	Insurance Telephone # (+Area Code)
Employer	Medicaid #

**ALTERNATE SHIPPING ADDRESS**

Last Name		First Name		M.I.
Street Address				
City		State	ZIP	

Caremark is committed to protecting the privacy of your health information. We will hold your health information in confidence and will only use and disclose it in accordance with applicable law.

**2. PHYSICIAN INFORMATION** *To be completed by the physician and staff*

Prescriber's Last Name		Prescriber's First Name		
Hospital/Clinic		Office Contact		
Street Address				
City		State	ZIP	
Telephone # (+Area Code)		Fax # (+Area Code)	E-Mail Address	
Prescriber's License #		DEA #	NPI #	
UPIN#		Medicaid License #		

**STATEMENT OF MEDICAL NECESSITY**

**PRIMARY DIAGNOSIS:**

<input type="checkbox"/> 253.2 Panhypopituitarism	<input type="checkbox"/> 253.0 Acromegaly
<input type="checkbox"/> 253.7 Iatrogenic Pituitary Disorder	<input type="checkbox"/> 253.3 Isolated Growth Hormone Deficiency
<input type="checkbox"/> 585 Chronic Renal Failure/Insufficiency	<input type="checkbox"/> 758.6 Gonadal Dysgenesis (Turner Syndrome)
<input type="checkbox"/> 783.43 Short Stature <input type="checkbox"/> Idiopathic Short Stature <input type="checkbox"/> Small for Gestational Age	
<input type="checkbox"/> 759.81 Prader-Willi Syndrome	<input type="checkbox"/> 259.1 Precocious Puberty
<input type="checkbox"/> 799.4 Cachexia	<input type="checkbox"/> 193 Malignant Neoplasm of Thyroid Gland
<input type="checkbox"/> Short Bowel Syndrome (Please indicate ICD-9 Code) _____	
<input type="checkbox"/> Other (Please indicate ICD-9 CM Code & Description) _____	

**PERTINENT MEDICAL HISTORY: FOR PEDIATRIC PATIENTS, PLEASE INCLUDE A GROWTH CHART.**

Visit Date / / Height \_\_\_\_ Weight \_\_\_\_ Annualized Growth Velocity \_\_\_\_

Bone Age & Date \_\_\_\_ / \_\_\_\_  Advanced  Delayed  Normal

Allergies \_\_\_\_ IGF-1 \_\_\_\_ BP3 \_\_\_\_

Tanner Stage \_\_\_\_ Next Clinic Visit \_\_\_\_

Has Patient Previously Been on Growth Hormone?  Yes  No

If Yes, Start Date & Product \_\_\_\_ / \_\_\_\_

Does This Patient Have an  Active/  History of Tumor/Malignancy?  Yes  No

If Yes, How Long Has Regrowth Been Absent? \_\_\_\_ Years

Other History \_\_\_\_

**PROVOCATIVE TEST RESULTS:**

Test #1	<input type="checkbox"/> N/A		
Agent	Date	Peak Value	Units
Test #2	<input type="checkbox"/> N/A		
Agent	Date	Peak Value	Units

**INJECTION TRAINING:**

Injection Training Will Be/Has Been Conducted By the Physician's Office?  Yes  No Date / /

I Would Like Caremark to Coordinate Injection Training?  Yes  No

**Rx**

<input type="checkbox"/> Humatrope®	<input type="checkbox"/> 5 mg Vial	<input type="checkbox"/> 6 mg	<input type="checkbox"/> 12 mg	<input type="checkbox"/> 24 mg Cartridge	<input type="checkbox"/> HumatroPen®
<input type="checkbox"/> Nutropin®	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 10 mg Vial			
<input type="checkbox"/> Nutropin AQ®	<input type="checkbox"/> 10 mg Vial	<input type="checkbox"/> 10 mg Cartridge	<input type="checkbox"/> AQ Pen®		
<input type="checkbox"/> Norditropin®	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 15 mg Cartridge	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 15 mg NordiPen®	
	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 10 mg	<input type="checkbox"/> 15 mg Nordiflex®		
<input type="checkbox"/> Genotropin®	<input type="checkbox"/> 1.5 mg	<input type="checkbox"/> 5.8 mg	<input type="checkbox"/> 13.8 mg Cartridge/Intra-Mix®	Miniquick®	____ mg
	<input type="checkbox"/> Pen 5	<input type="checkbox"/> Pen 12			
<input type="checkbox"/> Saizen®	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 8.8 mg Vial	<input type="checkbox"/> cool.click™	<input type="checkbox"/> 8.8 mg click.easy™	Cartridge <input type="checkbox"/> one.click™
<input type="checkbox"/> Serostim®	<input type="checkbox"/> 4 mg	<input type="checkbox"/> 5 mg	<input type="checkbox"/> 6 mg Vial	<input type="checkbox"/> Serojet™	
<input type="checkbox"/> Tev-Tropin™	<input type="checkbox"/> 5 mg Vial	<input type="checkbox"/> Inject-Ease®			
<input type="checkbox"/> Zorbtive™	<input type="checkbox"/> 8.8 mg Vial	<input type="checkbox"/> Lupron® Depot PED	<input type="checkbox"/> 7.5 mg	<input type="checkbox"/> 11.25 mg	<input type="checkbox"/> 15 mg Kit
<input type="checkbox"/> Geref® Diagnostic	<input type="checkbox"/> 50 mcg Vial	<input type="checkbox"/> Somavert®	<input type="checkbox"/> 10 mg Vial	<input type="checkbox"/> 15 mg Vial	<input type="checkbox"/> 20 mg Vial
<input type="checkbox"/> Other _____	<input type="checkbox"/> Thyrogen®	<input type="checkbox"/> 0.9 mg Vial			

*Ancillary Supplies and Kits Provided as Needed for Administration*

<b>Sig</b>	<b>Quantity</b>
<input type="checkbox"/> Refill ____ Months	<input type="checkbox"/> Substitution Allowed
<input type="checkbox"/> Dispense As Written	

**Prescriber's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**PHYSICIAN SPECIALTY:**  Endocrinologist  Other (Specify) \_\_\_\_\_

**3. FAX COMPLETED FORM TOLL-FREE TO CAREMARKCONNECT® @ 1-800-323-2445**

**Please include copies of the patient's insurance cards (front & back) when faxing the referral to expedite benefit clearance.**

**Thank you for choosing Caremark!**