

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"/> 253.3 Isolated Growth Hormone Deficiency
<input type="checkbox"/> 253.7 Iatrogenic Pituitary Disorder	<input type="checkbox"/> 259.1 Precocious Puberty
<input type="checkbox"/> 585 Chronic Renal Failure/Insufficiency	<input type="checkbox"/> 758.6 Gonadal Dysgenesis (Turner Syndrome)
<input type="checkbox"/> 759.81 Prader-Willi Syndrome	
<input type="checkbox"/> 783.43 Short Stature	<input type="checkbox"/> Idiopathic Short Stature <input type="checkbox"/> Small for Gestational Age
<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®	<input type="checkbox"/> 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"/> Tev-Tropin™	<input type="checkbox"/> 5 mg Vial	<input type="checkbox"/> Inject-Ease®			
<input type="checkbox"/> Geref® Diagnostic	<input type="checkbox"/> 50 mcg 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"/> Other _____					

Ancillary Supplies and Kits Provided as Needed for Administration.

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

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!