



SPECIALTY PHARMACY

# GROWTH HORMONE

Lake Mary, FL toll free

toll free fax

[krogerspecialtypharmacy.com](http://krogerspecialtypharmacy.com)

DATE: \_\_\_\_\_ NEEDS BY DATE: \_\_\_\_\_ SHIP TO:  PATIENT  OFFICE  OTHER \_\_\_\_\_

PATIENT INFO	
Patient Name	
Address	
City, State, Zip	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female

PRESCRIBER INFO		
Prescriber Name		
DEA #	NPI #	License #
Address		
City, State, Zip		
Phone	Fax	
Contact Person		

PLEASE FAX COPY OF:  PRESCRIPTION CARD FRONT & BACK  CLINICAL NOTES  MEDICAL CARD FRONT & BACK

## CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_

\*\* Diagnosis confirmed with appropriate lab testing and available upon request if insurance requires it

Drug Allergies: \_\_\_\_\_

Epiphysis open:  Yes  No Bone Age: \_\_\_\_\_ Growth Velocity: \_\_\_\_\_ Stim #1: / /  Pass  Fail

Patient Weight: \_\_\_\_\_ kg Patient Height: \_\_\_\_\_ Stim #2: / /  Pass  Fail

MED	DOSE/STRENGTH	SIG	QTY	RF
<input type="checkbox"/> Genotropin*	<input type="checkbox"/> cartridge: <input type="checkbox"/> 5mg <input type="checkbox"/> 12mg		1 month	_____
	<input type="checkbox"/> mini-quick*: <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*	<input type="checkbox"/> cartridge: <input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg		1 month	_____
	<input type="checkbox"/> vial: 5mg Dilute vial with _____ mL/diluent			
<input type="checkbox"/> Norditropin*	FlexPro*: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 15mg <input type="checkbox"/> 30mg		1 month	_____
<input type="checkbox"/> Nutropin* AQ	NuSpin* Pen: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg <input type="checkbox"/> 20mg		1 month	_____
<input type="checkbox"/> Omnitrope*	<input type="checkbox"/> cartridge: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg		1 month	_____
	<input type="checkbox"/> vial: 5.8mg			
<input type="checkbox"/> Saizen*	<input type="checkbox"/> vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg Dilute vial with _____ mL/diluent		1 month	_____
	<input type="checkbox"/> Click-Easy*: 8.8mg			
	<input type="checkbox"/> Saizenprep*: 8.8mg			
<input type="checkbox"/> Supprelin LA*	implant: 50mg		12 month	_____
<input type="checkbox"/> Zomacton*	vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg Dilute vial with _____ mL/diluent		1 month	_____
<input type="checkbox"/> Other			_____	_____

SUPPLIES  Pen Needles Size \_\_\_\_\_ Qty \_\_\_\_\_  Syringes Size \_\_\_\_\_ Qty \_\_\_\_\_

By signing this form and utilizing our services, you are authorizing Kroger Specialty Pharmacy™ and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Prescriber's Signature (no stamps) \_\_\_\_\_ Substitution Permitted \_\_\_\_\_ Date \_\_\_\_\_ Prescriber's Signature (no stamps) \_\_\_\_\_ Dispense As Written \_\_\_\_\_ Date \_\_\_\_\_

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