

Date: _____ Need By Date: _____ Ship To: Patient Office Other _____ Fax Copy: Rx Card Front/Back Clinical Notes Medical Card Front/Back

Patient Information		Prescriber Information		
Patient Name		Prescriber Name		
Address		Address		
City State Zip		City State Zip		
Main Phone	Alternate Phone	Phone	Fax	
Social Security #		Contact Person		
Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	DEA #	NPI #	License #

Clinical Information	
Diagnosis	ICD-10

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

Drug Allergies		
<input type="checkbox"/> Epiphysis Open: <input type="checkbox"/> No <input type="checkbox"/> Yes	Bone Age	Growth Velocity
Weight <input type="checkbox"/> kg <input type="checkbox"/> lbs	Height <input type="checkbox"/> ft <input type="checkbox"/> in	Stim #1: _____ / _____ / _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stim #2: _____ / _____ / _____ <input type="checkbox"/> Pass <input type="checkbox"/> Fail

Med	Dose/Strength	Sig	Qty	Refills
<input type="checkbox"/> Genotropin®	<input type="checkbox"/> Cartridge: <input type="checkbox"/> 5mg <input type="checkbox"/> 12mg <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		1 Month	_____
<input type="checkbox"/> Humatrope®	<input type="checkbox"/> Cartridge: <input type="checkbox"/> 6mg <input type="checkbox"/> 12mg <input type="checkbox"/> 24mg <input type="checkbox"/> Vial: <input type="checkbox"/> 5mg Dilute vial with _____ mL/diluent		1 Month	_____
<input type="checkbox"/> Lupron Depot-Ped (4 Week Supply)	Syringe: <input type="checkbox"/> 7.5mg (Weight: 25kg or less) <input type="checkbox"/> 11.25mg (Weight: >25-37.5kg) <input type="checkbox"/> 15mg (Weight: >37.5kg)		<input type="checkbox"/> 1 Kit	_____
<input type="checkbox"/> Lupron Depot-Ped (12 Week Supply)	Syringe: <input type="checkbox"/> 11.25mg <input type="checkbox"/> 30mg		<input type="checkbox"/> 1 Kit	_____
<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 <input type="checkbox"/> Vial: 5.8mg		1 Month	_____
<input type="checkbox"/> Saizen®	<input type="checkbox"/> Vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 8.8mg Dilute vial with _____ mL/diluent <input type="checkbox"/> Click-Easy®: 8.8mg <input type="checkbox"/> Saizenprep®: 8.8mg		1 Month	_____
<input type="checkbox"/> Supprelin LA®	Implant: 50mg		12 Month	_____
<input type="checkbox"/> Zomacton®	<input type="checkbox"/> Vial: <input type="checkbox"/> 5mg <input type="checkbox"/> 10mg Dilute vial with _____ mL/diluent		1 Month	_____
<input type="checkbox"/> Other				

Supplies	Qty	Size
<input type="checkbox"/> Pen Needles		
<input type="checkbox"/> Syringes		

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. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

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