

McKESSON

Empowering Healthcare

McKesson Specialty Pharmaceuticals
Customer Service Phone:
1-888-456-7274**Growth Hormone - THERAPY ENROLLMENT FORM**

Fax to 4D for Prior Authorization: 248-282-0471

Date Needed: _____ (MM / DD / YY)

**PATIENT INFORMATION:****PRESCRIPTION**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	SSN:
Patient Address: (include apt. #)			City:	State:	Zip:
Daytime Phone:		Evening Phone:		Best time to contact patient: <input type="checkbox"/> Morning <input type="checkbox"/> Evening	

INSURANCE INFORMATION: PLEASE SEND COPIES OF BOTH SIDES OF PHARMACY AND MEDICAL INSURANCE CARDS WITH THIS FORM.

Insured's Name:	Insured's SSN:	Insured's Employer or Group #:
Medical Insurance Name:	Medical ID#:	Medical Insurance Phone:
Pharmacy Insurance Name:	Pharmacy ID#:	Pharmacy Insurance Phone:
Secondary Insurance Name:	Secondary ID#:	Secondary Insurance Phone:
Prior Authorization:	Valid Through:	Is the patient Medicare primary? <input type="checkbox"/> Y <input type="checkbox"/> N

PRESCRIPTION INFORMATION (If attaching an Rx, please include the ICD-9 code and physician signature)

<input type="checkbox"/> Genotropin Pen 5/5.8 mg Cartridge <input type="checkbox"/> Genotropin Pen 12/13.8 mg Cartridge <input type="checkbox"/> Genotropin Mini Quick _____mg <input type="checkbox"/> Humatrope 5 mg Vials <input type="checkbox"/> Humatrope 6 mg Cartridge <input type="checkbox"/> Humatrope 12 mg Cartridge <input type="checkbox"/> Humatrope 24 mg Cartridge <input type="checkbox"/> Norditropin Pen/Cartridge 5 mg <input type="checkbox"/> Norditropin Pen/Cartridge 15 mg	<input type="checkbox"/> Nutropin 5 mg Vial <input type="checkbox"/> Nutropin 10 mg Vial <input type="checkbox"/> Nutropin AQ 10 mg/2 mL Vial <input type="checkbox"/> Nutropin AQ Pen/Cartridge 10 mg <input type="checkbox"/> Nutropin Depot 13.5 mg Vial <input type="checkbox"/> Nutropin Depot 18 mg Vial <input type="checkbox"/> Nutropin Depot 22.5 mg Vial <input type="checkbox"/> Saizen 5 mg Vial <input type="checkbox"/> Saizen 8.8 mg Vial	<input type="checkbox"/> Serostim 4 mg Vial <input type="checkbox"/> Serostim 5 mg Vial <input type="checkbox"/> Serostim 6 mg Vial Diluent Amount: _____ Injection Volume: _____ Dose: _____mg _____days/week Dose: _____mg/kg/week Refill: _____ times, or thru: _____ (date)
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Other Drug:	Dose: _____ mg	Qty: _____	Sig: _____	Refill: _____ months
Primary Diagnosis:	<input type="checkbox"/> Panhypopituitarism (253.2) <input type="checkbox"/> Iatrogenic pituitary disorders (253.7) <input type="checkbox"/> Idiopathic Short Stature (783.43)	<input type="checkbox"/> Pituitary Dwarfism (253.3) <input type="checkbox"/> Turner Syndrome (758.6) <input type="checkbox"/> HIV Wasting Syndrome (799.4)	<input type="checkbox"/> Chronic Renal Insufficiency (585.0) <input type="checkbox"/> Prader-Willi Syndrome (759.81) <input type="checkbox"/> Other: _____	

Weight: _____ (kg) Height: _____ (cm) Bone Age: _____ Growth Velocity: _____ **Please attach copies of the patient's progress notes and growth chart (required).** Applicable Medical History and clinical course:

Physician Signature: _____	<input type="checkbox"/> Generic substitution permissible <input type="checkbox"/> Dispense as written
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PHYSICIAN INFORMATION: If attaching an Rx, please include the ICD-9 code and physician signature.

Physician Name:	Specialty:	Contact Name:
Physician Address:	Phone #:	Secure Fax #:
Physician UPIN #:	Physician's DEA #:	License #:

SHIPPING INFORMATION**PATIENT MEDICAL INFORMATION**

Ship to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home (no PO Boxes please) <input type="checkbox"/> Other: _____ _____ _____ _____	Allergies (including food): _____ Current Medication Profile: (include OTCs & herbals) <table border="1"> <thead> <tr> <th>Drug</th> <th>Dose</th> <th>Directions</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Drug	Dose	Directions	_____	_____	_____	_____	_____	_____	_____	_____	_____
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Refrigerated prescriptions are shipped Mon. - Thurs. via standard overnight service. Non-refrigerated prescriptions are shipped Mon.-Fri. via 2-business day delivery. Saturday delivery requires approval from a pharmacist. For refills, please call-in or fax 7 days in advance of next appointment.

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