For assistance, contact your pharmacy representative: ______________________ Phone: ______________________ **(For providers only)**

Note: This form is intended for prescriber use only, if faxed, the fax must come from prescriber's office or hospital **(may not be faxed by patient)**.

Endocrinology

Prescription/Pharmacy Intake Form

Pharmacy: ______________________

Pharmacy Fax: ______________________ Pharmacy Phone: ______________________

Ship To: ☐Prescriber's Office ☐Patient's Home ☐Other: ______________________

Injection/Infusion Date: ______________ **Date Needed:** ______________ ☐Physician provides injection training

PATIENT INFORMATION

Patient name: ______________________ DOB: ______________ ☐Male ☐Female

Address: ______________________

City: ______________________ State: ______________ Zip code: ______________

Phone # (Daytime): ______________________ Phone # (Evening): ______________________

E-mail Address: ______________________ Case Manager: ______________________

Insurance provider **(Please include copy of front and back of card)**: ______________________

ID #: ______________ Policy/Group #: ______________ Phone #: ______________ ☐Patient is eligible for Medicare

Name of Insured: ______________________ Employer: ______________________

Relationship to Patient: ☐Self ☐Other: ______________ Prescription Card: ☐Yes ☐No Carrier: ______________ Policy/Group #: ______________

Will there be access to anaphylactic medications and oxygen at the administration site?_________

CLINICAL ASSESSMENT – Please complete ALL sections to avoid delays in filling prescription.

☐Patient is new to therapy ☐Patient is restarting therapy ☐Patient is currently on therapy Start date: ______________

Primary Diagnosis Code and Condition (ICD-10) **(REQUIRED)**: ______________________ Date of Diagnosis: ______________

Other Diagnosis/Conditions: ______________________

Current Height: ___________ ☐in ☐cm Date: ___________ Bone Age: ___________ Growth Velocity: ___________

☐Other Therapies Tried & Failed (Please List): ______________________

Allergies: ______________________

PRESCRIPTION INFORMATION

Genotropin Qty _____ Refills _____
- ☐5mg cartridge
- ☐12mg cartridge
- ☐Miniquik PFS Strength: _________

Directions: ______________________

Humatrope Qty _____ Refills _____
- ☐5mg vial
- ☐6mg cartridge
- ☐12mg cartridge
- ☐24mg cartridge

Directions: ______________________

☐**Humatropen** (device for injection)

Increlex Qty _____ Refills _____
- ☐4mL vial (10mg/1mL)

Directions: ______________________

Lupron Depot Qty _____ Refills _____
- ☐7.5mg (once monthly)
- ☐22.5mg (every 12 weeks)
- ☐30mg (every 16 weeks)
- ☐45mg (every 24 weeks)

Directions: ______________________

Lupron Depot-Ped (Pediatric) Qty _____ Refills _____
- ☐7.5mg (once monthly)
- ☐11.25mg (once monthly)
- ☐15mg (once monthly)
- ☐11.25mg (every 3 months)
- ☐30mg (every 3 months)

Directions: ______________________

Norditropin Flexpro Qty ____ Refills ______
- ☐5mg/1.5mL
- ☐10mg/1.5mL
- ☐15mg/1.5mL
- ☐30mg/3mL

Directions: ______________________

Nutropin AQ NUSPIN Pen Qty ____ Refills ______
- ☐5mg
- ☐10mg
- ☐20mg

Directions: ______________________

Omnitrope* Qty ____ Refills ______
- ☐5.8mg MDV
- ☐5mg cartridge
- ☐10mg cartridge

Directions: ______________________

Sandostatin LAR Depot Qty ____ Refills ______
- ☐10mg kit
- ☐20mg kit
- ☐30mg kit

Directions: ______________________

Skytrofa Qty _____ Refills ______
- ☐3mg cartridge
- ☐3.6mg cartridge
- ☐4.3mg cartridge
- ☐5.2mg cartridge
- ☐6.3mg cartridge
- ☐7.6mg cartridge
- ☐9.1mg cartridge
- ☐11mg cartridge
- ☐13.3mg cartridge

Directions: ______________________

Somatuline Depot Qty _____ Refills ______
- ☐60mg/0.2ml PFS
- ☐90mg/0.3ml PFS
- ☐120mg/0.5ml PFS

Directions: ______________________

Supprelin LA Qty 1 Refills N/A
- ☐50mg implant (implant kit included)

Directions: ______________________

Contact phone number for surgeon's office doing implantation ______________________

Zomacton Qty _____ Refills ______
- ☐5mg vial
- ☐10mg vial
- ☐10mg vial with vial adapter

Directions: ______________________

***For Omnitrope device please contact Access Sandoz Program at 877-828-1052(fax) or 877-456-6794(phone).**

I authorize, by my signature below, the dispensing of appropriate needles and syringes, in a sufficient quantity, required for the administration of injectable products by patient or caregiver. Authorization for supplies runs concurrently with the number of refills or time frame specified for the drug.

PRESCRIBER INFORMATION

Prescriber's name: ______________________ Practice/facility: ______________________

Address: ______________________ City: ______________ State: _________ Zip code: ______________

Office contact: ______________________ Phone: ______________ Fax: ______________

Email: ______________________ Best time to call: ______________ Preferred method of contact: ☐Email ☐Phone ☐Fax

State license #: ______________ DEA #: ______________ NPI #: ______________ Medicaid UPIN #: ______________

In order for a brand name product to be dispensed, the prescriber must handwrite **"Brand Necessary"** or **"Brand Medically Necessary"** or your state specific required language after their signature. I certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge. Prescriber's signature required on one of the lines below.

______________________ Dispense as written

______________________ Substitution permitted

______________________ Date

The prescriber is to comply with his/her state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

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Drug names are the property of their respective owners.

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