BioPlus® Specialty Pharmacy
A Carelon Company

# Growth Hormone

Fax: 800-269-5493 Phone: 888-292-0744 bioplusrx.com

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

## Patient Information

| | |
|---|---|
| Patient Name | |
| Address | |
| City State Zip | |
| Main Phone | Alternate Phone |
| Social Security # | |
| Date of Birth | ☐Female ☐Male |

## Prescriber Information

| | | |
|---|---|---|
| Prescriber Name | | |
| Address | | |
| City State Zip | | |
| Phone | Fax | |
| Contact Person | | |
| DEA # | NPI # | License # |

## Clinical Information

| | |
|---|---|
| Diagnosis | ICD-10 |

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

| | | |
|---|---|---|
| ☐Epiphysis Open: ☐No ☐Yes | Bone Age | Growth Velocity |
| Weight ☐kg ☐lbs | Height ☐ft ☐in | Stim #1: _____ / _____ / _____ ☐Pass ☐Fail<br>Stim #2: _____ / _____ / _____ ☐Pass ☐Fail |
| Drug Allergies | | Status:<br>☐New ☐Restart ☐Continuing |

| Med | Dose/Strength | Sig | Qty | Refills |
|---|---|---|---|---|
| ☐Genotropin® | ☐Cartridge: ☐5mg ☐12mg<br>☐Mini-quick®: ☐0.2mg ☐0.4mg ☐0.6mg ☐0.8mg ☐1mg ☐1.2mg ☐1.4mg ☐1.6mg ☐1.8mg ☐2mg | | 1 Month | _____ |
| ☐Humatrope® | ☐Cartridge: ☐6mg ☐12mg ☐24mg<br>☐Vial: ☐5mg Dilute vial with _____ mL/diluent | | 1 Month | _____ |
| ☐Lupron Depot-Ped (4 week supply) | Syringe: ☐7.5mg (weight: 25kg or less) ☐11.25mg (weight: >25-37.5kg) ☐15mg (weight: >37.5kg) | | ☐1 Kit | _____ |
| ☐Lupron Depot-Ped (12 week supply) | Syringe: ☐11.25mg ☐30mg | | ☐1 Kit | _____ |
| ☐Ngenla™ | Prefilled Pen: ☐24mg ☐60mg | | 1 Month | _____ |
| ☐Norditropin® | FlexPro®: ☐5mg ☐10mg ☐15mg ☐30mg | | 1 Month | _____ |
| ☐Nutropin® AQ | NuSpin® Pen: ☐5mg ☐10mg ☐20mg | | 1 Month | _____ |
| ☐Omnitrope® | ☐Cartridge: ☐5mg ☐10mg<br>☐Vial: 5.8mg | | 1 Month | _____ |
| ☐Skytrofa® | Cartridge: ☐3mg ☐3.6mg ☐4.3mg ☐5.2mg ☐6.3 mg ☐7.6mg ☐9.1mg ☐11mg ☐13.3mg | | 1 Month | _____ |
| ☐Sogroya® | Pen: ☐5mg ☐10mg ☐15mg | | 1 Month | _____ |
| ☐Supprelin LA® | Implant: 50mg | | 12 Month | _____ |
| Zomacton® | Vial: ☐5mg ☐10mg<br>Dilute vial with _____ mL/diluent | | 1 Month | _____ |
| ☐ Other | | | | |

| Supplies | Qty | Size |
|---|---|---|
| ☐ Pen Needles | | |
| ☐ Syringes | | |

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payors with respect to this prescription and any refills or continuation of the same medication and dose for this patient. 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**