

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

PLEASE CONSIDER SENDING YOUR PRESCRIPTION ELECTRONICALLY. ALL OF OUR PHARMACY LOCATIONS ACCEPT ELECTRONIC PRESCRIPTIONS.

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: _____ Saizen Qty _____ Refills _____ 5mg vial 8.8mg vial 8.8mg Click Easy cartridge Directions: _____ Sandostatin LAR Depot Qty _____ Refills _____ 10mg kit 20mg kit 30mg kit 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: _____

*AllianceRx Walgreens Pharmacy does not dispense 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

*** THIS FORM IS NOT VALID IN THE STATE OF ALABAMA ***

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. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Drug names are the property of their respective owners.