

Ship to:  Patient  Office  Other

Date: \_\_\_\_\_ Needs by Date: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Address 2 \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Preferred Phone \_\_\_\_\_ Type \_\_\_\_\_  
 Alternate Phone \_\_\_\_\_ Type \_\_\_\_\_  
 Email \_\_\_\_\_  
 DOB (mm/dd/yyyy) \_\_\_\_\_ Gender  Male  Female

## PRESCRIBER INFORMATION

Prescriber Name \_\_\_\_\_ Specialty \_\_\_\_\_  
 State License # \_\_\_\_\_ UPIN \_\_\_\_\_  
 DEA \_\_\_\_\_ NPI \_\_\_\_\_  
 Group/Hospital \_\_\_\_\_  
 Address \_\_\_\_\_  
 City, State, ZIP \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Office Contact \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION (Please fax FRONT and BACK copy of all Insurance cards (Prescription and Medical))

### CLINICAL INFORMATION

**Diagnosis (Please include diagnosis name and ICD-10)**  
 Diagnosis: \_\_\_\_\_ ICD-10 Code: \_\_\_\_\_  
 Date of Diagnosis: \_\_\_\_\_  
 Weight: \_\_\_\_\_ lbs/kg Height: \_\_\_\_\_ in/cm  
 Is the patient pregnant, nursing, or planning pregnancy?  Yes  No  N/A  
 Creatinine: \_\_\_\_\_ Date: \_\_\_\_\_  
 IGF-1: \_\_\_\_\_ BP3: \_\_\_\_\_  
 Provocative Test Results:  
 Agent \_\_\_\_\_ Date: \_\_\_\_\_  
 Peak Value: \_\_\_\_\_ Units: \_\_\_\_\_  
 Agent \_\_\_\_\_ Date: \_\_\_\_\_  
 Peak Value: \_\_\_\_\_ Units: \_\_\_\_\_

Therapy:  New  Continuing Therapy  Restart  
 Concomitant medications: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Has the patient been previously treated for this condition?  Yes  No  
 Prior failed medication (medication and duration of treatment/reason for d/c): \_\_\_\_\_  
 Who will administer injection? (if applicable): \_\_\_\_\_  
 Patient trained on injection? (if applicable):  Yes  No  
 Pharmacy injection training needed? (if applicable):  Yes  No  
 Additional comments: \_\_\_\_\_  
*Please attach recent clinical notes, including growth charts/velocity.*

### PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Qty	Refills
<input type="radio"/> Genotropin® (somatropin)	<input type="radio"/> <b>Cartridge:</b> <input type="radio"/> 5mg <input type="radio"/> 12mg <input type="radio"/> <b>Mini-Quick:</b> <input type="radio"/> 0.2mg <input type="radio"/> 0.4mg <input type="radio"/> 0.6mg <input type="radio"/> 0.8mg <input type="radio"/> 1mg <input type="radio"/> 1.2mg <input type="radio"/> 1.4mg <input type="radio"/> 1.6mg <input type="radio"/> 1.8mg <input type="radio"/> 2mg			
<input type="radio"/> Humatrope® (somatropin)	<input type="radio"/> <b>Cartridge:</b> <input type="radio"/> 6mg <input type="radio"/> 12mg <input type="radio"/> 24mg <input type="radio"/> <b>Vial:</b> <input type="radio"/> 5mg			
<input type="radio"/> Increlex® (mecasermin injection)	<input type="radio"/> 40mg/4ml vial			
<input type="radio"/> Norditropin® (somatropin)	<input type="radio"/> <b>FlexPro® Pen</b> <input type="radio"/> 5mg/1.5mL <input type="radio"/> 10mg/1.5mL <input type="radio"/> 15mg/1.5mL <input type="radio"/> 30mg/3mL			
<input type="radio"/> Nutropin AQ® (somatropin)	<input type="radio"/> <b>NuSpin® Pen:</b> <input type="radio"/> 5mg/2ml <input type="radio"/> 10mg/2ml <input type="radio"/> 20mg/2ml			
<input type="radio"/> Omnitrope® (somatropin)	<input type="radio"/> 5mg/1.5ml <input type="radio"/> 10mg/1.5ml <input type="radio"/> 5.8mg/vial			
<input type="radio"/> Saizen® (somatropin)	<input type="radio"/> <b>Click Easy Cartridge:</b> <input type="radio"/> 8.8mg <input type="radio"/> <b>Vial:</b> <input type="radio"/> 5mg <input type="radio"/> 8.8mg			
<input type="radio"/> Zorbtive® (somatropin)	<input type="radio"/> 8.8mg vial			
<input type="radio"/> Zomacton (vial) (somatropin)	<input type="radio"/> 5mg <input type="radio"/> 10mg			
<input type="radio"/> Pen Needles	Size: _____ Quantity: _____			
<input type="radio"/> Syringes	Size: _____ Quantity: _____			

By signing below, I authorize Lumicera Health Services and its representatives to act as my agent for prior authorization and prescription processing for this patient.

Prescriber Signature: \_\_\_\_\_ Date \_\_\_\_\_ *DISPENSE AS WRITTEN*

PRODUCT SUBSTITUTION PERMITTED

Date

DISPENSE AS WRITTEN