US Bioservices
AmerisourceBergen

Growth Hormone Referral Form

Phone: (866) 223-2050
Fax: (888) 418-7246

Deliver to: ☐ Patient's Home ☐ Prescriber's Office ☐ Other: ________ ☐ Hold shipment until notified by prescriber ☐ Anticipated Start Date: ________

1. Patient Information

Last Name: ________ Home Phone: ________ Work / Mobile Phone: ________

First Name: ________ Home Address: ________

S.S. #: ________ Date of Birth: ________ City: ________ State: ________ Zip: ________

Guardian / Caregiver: ________ Sex: ☐ Male ☐ Female Height: ________ Weight: ________ ☐ lb ☐ kg

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription and medical)

Medical Insurance: ________ Phone: ________ Prescription Card: ________ Phone: ________

Subscriber Name: ________ Policy #: ________ BIN / PCN: ________

Policy #: ________ Group #: ________ Medicare #: ________ Medicaid #: ________

3. Prescriber Information

Prescriber Name: ________ ☐ MD ☐ DO ☐ NP ☐ PA License #: ________ NPI #: ________ DEA #: ________

Practice Name: ________ Phone: ________ Fax: ________

Address: ________ Office Contact: ________ Phone: ________

City: ________ State: ________ Zip: ________ Collaborating Physician: ________

4. Diagnosis and Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Primary ICD-10: ________ Meds Tried / Failed: ________

Secondary ICD-10: ________ ________

Allergies: ________ Concurrent Medications: ________

Vaccination History: ________ ________

5. Prescription Information

Medication	Dose / Strength	Directions	Dispense	Refills
☐ **Genotropin®**	**Genotropin Cartridge:** ☐ 5 mg ☐ 12 mg **Genotropin MiniQuick®:** ☐ 0.2 mg ☐ 0.4 mg ☐ 0.6 mg ☐ 0.8 mg ☐ 1.0 mg ☐ 1.2 mg ☐ 1.4 mg ☐ 1.6 mg ☐ 1.8 mg ☐ 2.0 mg	Inject ________ mg SC once daily, ________ days per week		
☐ **Humatrope® Cartridge**	☐ 6 mg (Gold) ☐ 12 mg (Purple) ☐ 24 mg (Teal)	Inject ________ mg SC once daily, ________ days per week		
☐ **Norditropin FlexPro® Pen**	☐ 5 mg/1.5 mL (Orange) ☐ 10 mg/1.5 mL (Blue) ☐ 15 mg/1.5 mL (Green) ☐ 30 mg/3 mL (Purple)	Inject ________ mg SC once daily, ________ days per week		
☐ **Nutropin AQ NuSpin®**	☐ 5 mg/2 mL ☐ 10 mg/2 mL ☐ 20 mg/2 mL	Inject ________ mg SC once daily, ________ days per week		
☐ **Omnitrope®**	**Cartridge:** ☐ 5 mg/1.5 mL ☐ 10 mg/1.5 mL **Vial:** ☐ 5.8 mg	Inject ________ mg SC once daily, ________ days per week		
☐ **Saizen®**	☐ 5 mg LYO ☐ 8.8 mg LYO ☐ 8.8 mg Click.easy® Cartridge	Inject ________ mg SC once daily, ________ days per week		
☐ **Somavert® PDS Kit**	☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 25 mg ☐ 30 mg	Inject ________ mg SC once daily, ________ days per week		
☐ **Other:**		Inject ________ mg SC once daily, ________ days per week		

Patient Support Programs: Please have patient sign and date to enroll in pharmaceutical company assisted patient support program.

Patient Signature ________ Date ____ / ____ / ____

Account Manager

____

Prescriber Authorization (No stamps. Signature and date must be completed in prescriber's handwriting. NY prescriptions must be submitted via e-script.)

I authorize US Bioservices Corporation to act as my representative and on behalf of myself and my patient to initiate any authorization processes from applicable health plans, if needed, including the submission of any necessary forms to such health plans.

Prescriber Signature-Substitution Permissible PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

Prescriber Signature-Dispense as Written PRESCRIBER SIGNATURE REQUIRED. NO STAMPS. ________ Date ____ / ____ / ____

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