Cosentino's SPECIALTY CARE

GROWTH HORMONE DEFICIENCY DISORDER

Phone: **833-796-6470** • Fax: **844-841-3401**

KLOUDSCRIPT Community Led Specialty Pharmacy Care

1 PATIENT INFORMATION:

Name: ____________________
Address: ____________________
City: ____________ State: ____ Zip: ________
Phone: ____________ Alt. Phone: ____________
Email: ____________________
DOB: ________ Gender: ❍ M ❍ F Caregiver: ________
Height: ______ Weight: ______ Allergies: ________

2 PRESCRIBER INFORMATION:

Name: ____________________
Address: ____________________
City: ____________ State: ____ Zip: ________
Phone: ____________ Fax: ____________
NPI: ____________ DEA: ____________
Tax I.D.: ____________________
Office Contact: ____________ Phone: ____________

v9.0_053121

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: ____________ ICD-10: ________ ICD-10 Description: ________ Others: ________ Description: ________

Weight: ______ ❑ lb ❑ kg

Prior Tried and Failed Therapies:

1 ____________
2 ____________
3 ____________
4 ____________
5 ____________

Height: ____________ ❑ in ❑ cm

Indicate length of therapy: ________

Contraindication to growth hormone therapy:
- ❑ Active malignancy
- ❑ Acute critical illness
- ❑ Active proliferative diabetic retinopathy

For female patients: Is the patient currently on estrogen containing oral contraceptive? ❑ Yes ❑ No ❑ N/A

Serum Insulin-like Growth Factors-1 (IGF-1): ________ ng/mL

Insulin-like Growth Factor Binding Protein 3 (IGFBP-3): ________ ng/mL

Does patient have dyslipidemia? ❑ Yes ❑ No

Does patient have diagnosis of osteopenia or osteoporosis? ❑ Yes ❑ No

Does patient have diagnosis of diabetes mellitus? ❑ Yes ❑ No

©2020 KloudScript, Inc. - All rights reserved.

Genetic syndromes:
❑ Turner syndrome ❑ Prader-Willi syndrome ❑ Noonan syndrome
❑ Down syndrome ❑ Bloom syndrome

Was patient previously diagnosed with structural hypothalamic/pituitary disease or have evidence of other pituitary hormone deficiency? ❑ Yes ❑ No

If yes, have the patient undergone hypothalamic/pituitary surgery or irradiation? ❑ Yes ❑ No

PROVOCATIVE TESTS:

- ❑ Insulin Intolerance Test (ITT) Date: ________
- ❑ Growth Hormone-Releasing Hormone (GHRH) Argininge Test Date: ________
- ❑ Glucagon Stimulation Test Date: ________

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING:

❍ To Be Administered by Pharmacist (State of Missouri Only) ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PICK UP OR DELIVERY:

❍ Delivery to Patient's Home ❍ Delivery to Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: ____________________ Patient's Date of Birth: ____________

Medication	Dosage & Strength	Direction	QTY	Refills
❑ GENOTROPIN® (SOMATROPIN)	Genotropin Lyophilized Powder in Cartridge: ❑ 5 mg ❑ 12mg Genotropin MINIQUICK Cartridge (Preservative Free): ❑ 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 mg	❑ ________		
❑ HUMATROPE® (SOMATROPIN)	❑ 5 mg vial with 5-mL diluent vial Cartridge with Prefilled Syringe of Diluent: ❑ 6 mg ❑ 12 mg ❑ 24 mg	❑ ________		
❑ SAIZEN® (SOMATROPIN)	Saizen: ❑ 5.5 mg vial ❑ 8.8 mg vial Saizen Click.Easy: ❑ 4 mg vial ❑ 8.8 mg vial Saizenprep: ❑ 8.8 mg	❑ ________		
❑ SOGROYA (SOMAPACITAN-BECO)	❑ 10 mg/1.5 mL single-patient use prefilled pen	❑ ________		
❑ ZOMACTON® (SOMATROPIN)	❑ 5 mg vial ❑10 mg vial ❑10 mg vial (for Zoma-Jet)	❑ ________		
❑ ________	________	________		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: ____________ Date: ________ Signature: ____________ Date: ________

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

Confidentiality Notice: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please inform the sender immediately if you have received this document in error and then destroy this document immediately.