

Send updates to:  Fax: \_\_\_\_\_  Email: \_\_\_\_\_

**Physician Information**

Prescriber Name:		<input type="radio"/> MD <input type="radio"/> DO <input type="radio"/> NP <input type="radio"/> PA		NPI:
Office Contact:		Practice Name / Supervising MD:		
Address:		City:		
State:	Zip:	Phone:	Fax:	

**Patient Information | PLEASE SEND COPY OF INSURANCE CARD**

Patient's Name:	Last 4 Digits of SS#:	DOB: / /	Sex: <input type="radio"/> M <input type="radio"/> F	Weight:	Height:	Diabetic: <input type="radio"/> Y <input type="radio"/> N
Address:	City:	State:	Zip:	Allergies:		
Home Phone:	Work Or Cell:	HIPAA Contact:	Emergency #:	Interpreter Needed? <input type="radio"/> Y <input type="radio"/> N		

**Insurance Information**

Primary Insurance:	Policy ID:	Group #:
Policyholder Name:	Policyholder DOB:	BIN: PCN:

**Clinical Information | PLEASE FAX ALL PERTINENT CLINICAL AND LAB INFORMATION**

Diagnosis Code:	<input type="radio"/> E23.0 (Hypopituitarism) <input type="radio"/> E23.1 (Drug-Induced Hypopituitarism) <input type="radio"/> E34.3 (Short Stature due to Endocrine Disorder) <input type="radio"/> Other: <input type="radio"/> Q87.1 (Congenital Malformation Syndromes predominantly associated with Short Stature) <input type="radio"/> Q96.9 (Turner's Syndrome) <input type="radio"/> R62.52 (Pediatric Short Stature)					
Height: cm	Weight: kg	Date Measured: / /	Prior Therapy? <input type="radio"/> Yes <input type="radio"/> No (provide information below)			
Prior Therapy			Reason for Discontinuation of Therapy			
Comorbidities:	Concomitant Medications:			Allergies: <input type="radio"/> NKDA <input type="radio"/> Other:		

**Prescription Information**

Medication	Dose/Strength	Directions	Qty	Refills
<input type="radio"/> <b>GENOTROPIN®</b> (somatropin)	<b>Cartridge:</b> <input type="radio"/> 5mg <input type="radio"/> 12mg <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"/> <b>HUMATROPE®</b> (somatropin)	<b>Cartridge:</b> <input type="radio"/> 6mg <input type="radio"/> 12mg <input type="radio"/> 24mg <b>Vial:</b> <input type="radio"/> 5mg			
<input type="radio"/> <b>LUPRON DEPOT-PED®</b> (leuprolide)	<b>1-Month Administration:</b> <input type="radio"/> 7.5mg <input type="radio"/> 11.25mg <input type="radio"/> 15mg <b>3-Month Administration:</b> <input type="radio"/> 11.25mg <input type="radio"/> 30mg	<input type="radio"/> Inject into the muscle once a month <input type="radio"/> Inject into the muscle once every 3 months		
<input type="radio"/> <b>NORDITROPIN®</b> (somatropin)	<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"/> <b>NUTROPIN AQ®</b> (somatropin)	<b>NuSpin® Pen:</b> <input type="radio"/> 5mg/2mL <input type="radio"/> 10mg/2mL <input type="radio"/> 20mg/2mL			
<input type="radio"/> <b>OMNITROPE®</b> (somatropin)	<b>Cartridge:</b> <input type="radio"/> 5mg/1.5mL <input type="radio"/> 10mg/1.5mL <b>Vial:</b> <input type="radio"/> 5.8mg/vial			
<input type="radio"/> <b>SAIZEN®</b> (somatropin)	<b>SAIZENPREP® Cartridge:</b> <input type="radio"/> 8.8mg <b>Vial:</b> <input type="radio"/> 5mg <input type="radio"/> 8.8mg			
<input type="radio"/> <b>SEROSTIM®</b> (somatropin)	<b>Vial:</b> <input type="radio"/> 4mg <input type="radio"/> 5mg <input type="radio"/> 6mg			
<input type="radio"/> <b>SUPPRELIN LA®</b> (histrelin)	<b>Implant:</b> <input type="radio"/> 50mg	Insert 1 implant into the inner aspect of the upper arm every 12 months.	1	No Refills
<input type="radio"/> <b>ZOMACTON®</b> (somatropin)	<b>Vial:</b> <input type="radio"/> 5mg <input type="radio"/> 10mg			
<input type="radio"/> Other				

**Injection Training**

Patient received injection training
  Prescriber's office to provide injection training
  Meijer to coordinate injection training

By signing this form and utilizing our services, you are authorizing Meijer and its employees to serve as your prior authorization designated agent in dealing with medical and prescription insurance companies.

Physician Signature:	Date	Physician Signature:	Date
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