aetna®

Growth Hormone Medication Request

Aetna Specialty Pharmacy®
503 Sunport Lane
Orlando, FL 32809

Customer Service: 1-866-782-ASRX (1-866-782-2779) **Fax Order Submission: 1-866-FAX-ASRX (1-866-329-2779)**

For your convenience, this medication request may be submitted via E-PRESCRIBE to Aetna Specialty Pharmacy

Aetna Specialty Pharmacy will verify benefits and contact members to confirm delivery before medication is shipped.

Today's Date: **Date Needed:**

A. PATIENT INFORMATION

First Name:	Last Name:	DOB:	
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
Weight:	Height:	Allergies:	

B. INSURANCE INFORMATION

Carrier Name: _____
Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, Carrier Name: _____
Member ID#: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, ID #: **Medicaid**: ☐ Yes ☐ No If yes, ID #:

C. PHYSICIAN INFORMATION

First Name:		Last Name: *(Check one)*: ☐M.D. ☐D.O. ☐N.P. ☐P.A.		
Address:		City:	State:	ZIP:
Phone:	Fax:	DEA #:	NPI #:	Office Contact:

D. DIAGNOSIS

Primary ICD Code: Other ICD Code:

E. PRESCRIPTION

Please refer to the insurance carrier's participating provider precertification list to verify precertification requirements.

Medication	Directions	Quantity	Refills
☐ GENOTROPIN **Cartridge** ☐5mg ☐12 mg ☐ GENOTROPIN **Miniquick** ☐0.2mg ☐0.4mg ☐0.6mg ☐0.8mg ☐1mg ☐1.2mg ☐1.4mg ☐1.6mg ☐1.8mg ☐2mg	***DOSE:*** _____mg SQ daily, _____ days a week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ HUMATROPE 5mg **Powder Vial:** ***Mix*** w/ _____ml diluent ☐ HUMATROPE **Cartridge** ☐6mg ☐12mg ☐24mg ☐ PEN Device	***DOSE:*** _____mg SQ daily, _____ days a week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐NORDITROPIN **Flexpro** Pen ☐5mg ☐10mg ☐15mg ☐30mg	***DOSE:*** _____mg SQ daily, _____ days a week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ NUTROPIN AQ **Nuspin** Pen ☐5mg ☐10mg ☐20mg	***DOSE:*** _____mg SQ daily, _____ days a week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ OMNITROPE 5.8mg **Powder Vial**: ***Mix*** w/ _____ml diluent ☐ OMNITROPE **Cartridge** ☐5mg ☐10mg **(PEN Device available through Omnisource 1-877-456-6794)**	***DOSE:*** _____mg SQ daily, _____ days a week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ SAIZEN **CLICK.EASY** 8.8mg ☐ SAIZEN**PREP** 8.8mg ☐ **Cartridge with EasyPod** Device Dose Adjustment: ☐Off ☐>50% ***OR*** Auto: ☐10% ☐25% ☐50% ☐ **Cartridge with OneClick** Device (Note: dosed in clicks 0.11-0.12mg per click) ☐ SAIZEN **Powder Vial** ☐8.8mg ☐5mg ***Mix*** w/ _____ml diluent ☐ Needle/syringe	***DOSE:*** _____mg SQ daily, _____ days a week ☐ Other:	☐ 1 month ☐ 3 months ☐ Other:	
☐ Other		☐ 1 month ☐ 3 months ☐ Other:	
☐ Other:		☐ 1 month ☐ 3 months ☐ Other:	

Supply Preference:

Ship to: ☐ Physician's Office ☐ Patient ☐ Other address:

*Interchange is mandated unless practitioner handwrites the words **"MEDICALLY NECESSARY"** for each medication.*

Prescriber's Signature **(Required by Law):**

Aetna Specialty Pharmacy refers to Aetna Specialty Pharmacy, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy that operates through specialty pharmacy prescription fulfillment. This pharmacy is a for-profit entity