



Patient Referral/ Medication Request Growth Hormone

Aetna Specialty Pharmacy®
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Today's Date:

Anticipated Start Date:

PATIENT INFORMATION

First Name:		Last Name:	
Address:		City:	State: ZIP:
Home Phone:		Work Phone:	Cell Phone:
DOB:	Height:	Weight:	Allergies:
Ship Meds to: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Doctor's Office		Email Address:	

INSURANCE INFORMATION

Primary Insurance:		Pharmacy Benefit Manager (PBM):	
Policy #:	Group #:	Insured:	Phone:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, provide #:
Secondary Insurance:			
Policy #:	Group #:	Insured:	Phone:

PHYSICIAN INFORMATION

First Name:		Last Name:		M.D./D.O.	
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic. #:	NPI #:	DEA #:	UPIN:
Office Contact Name:			Email Address:		Phone:

DIAGNOSIS:

Primary:	ICD 9:	Secondary:	ICD 9:
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Please refer to Clinical Policy Bulletin #0170 for formulary information.

(P) **NUTROPIN VIAL (POWDER):** Mix w/ ____ mL diluent
 10mg

(P) **NUTROPIN AQ 10MG/2ML VIAL**

(P) **NUTROPIN AQ CARTRIDGE** **PEN DEVICE**
 10mg 20mg

(P) **NUTROPIN AQ NUSPIN PEN**
 5mg 10mg 20mg
 QTY: _____ REFILLS: _____
Directions:

(P) **HUMATROPE CARTRIDGE** **PEN DEVICE**
 6mg 12mg 24mg

(P) **HUMATROPE 5MG VIAL (POWDER):** Mix w/ ____ mL diluent
 QTY: _____ REFILLS: _____
Directions:

(P) **TEV-TROPIN 5MG VIAL (POWDER)**
 Mix w/ ____ mL diluent **OR** Patient using T-Jet Device
 QTY: _____ REFILLS: _____
Directions:

(P) **SAIZEN 8.8MG CLICK EASY CARTRIDGE**

(P) **SAIZEN VIAL (POWDER)** Mix w/ ____ mL diluent
 5mg 8.8mg
 INDICATE INJECTION DEVICE PATIENT USES:

 QTY: _____ REFILLS: _____
Directions:

(P) = Preferred
 (NP) = Non-Preferred
 (ST) = Step-Therapy

(ST) **GENOTROPIN CARTRIDGE**
 5mg 12 mg

(ST) **GENOTROPIN MINIQUICK**
 0.2mg 0.4mg 0.6mg 0.8mg 1.0mg
 1.2mg 1.4mg 1.6mg 1.8mg 2mg
 QTY: _____ REFILLS: _____
Directions:

(ST) **OMNITROPE 5.8MG VIAL (POWDER)** Mix w/ ____ mL diluent

(ST) **OMNITROPE CARTRIDGE**
 5mg 10mg
 QTY: _____ REFILLS: _____
Directions:

(ST) **NORDITROPIN FLEXPEN PEN**
 5mg 10mg 15mg
 QTY: _____ REFILLS: _____
Directions:

(NP) **ZORBIVIVE 8.8MG VIAL (POWDER)** Mix w/ ____ mL diluent
 QTY: _____ REFILLS: _____
Directions:

OTHER _____
 QTY: _____ REFILLS: _____
Directions:

PLEASE SPECIFY SUPPLY PREFERENCE:
 Pen Needles SIZE: _____ QTY: _____
 Insulin Syringes SIZE: _____ QTY: _____
 Needle/ Syringes to Reconstitute SIZE: _____ QTY: _____

Prescriber's Signature Required by Law: _____ **Date:** _____