KnippeRx™ Specialty Pharmacy Services

Growth Hormone Referral Form

Phone: (855) 647-7379
Fax: (855) 774-3879

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

1. Patient Information

Last Name: _____ First Name: _____ Home Phone:_____ Work/Mobile Phone:_____

S.S. #: _____ Date of Birth: _____ Home Address:_____

Guardian/Caregiver:_____ City:_____ State:_____ Zip:_____

Patient Preferred Language:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____ ☐ lbs. ☐ kg.

2. Patient Insurance Information (Please fax front and back copy of all insurance cards - prescription & 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 & Clinical Information (Please fax recent clinical notes, labs and tests, with the prescription to expedite the prior authorization)

Needs by Date: _____

Ship to: ☐ Patient ☐ MD Office ☐ Other_____

Diagnosis (ICD-10): E23.0 Hypopituitarism N18.9 Chronic Kidney Disease, Unspecified P05.10 Small Gestational Age Q87.1 Prader-Willi Syndrome Q87.89 Other Specified Congenital Malformation Syndromes, Not Elsewhere Classified Q89.8 Other Specified Congenital Malformations Q96.9 Turner Syndrome R62.52 Idiopathic Short Stature (ISS)

Other Code: _____ Description: _____

Patient Clinical Information:

Allergies: _____

Nursing: Specialty Pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No

5. Prescription Information

Genotropin:
1.5 mg Intra-Mix
5.8 mg Intra-Mix®
5 mg pen cartridge
12 mg pen cartridge

MiniQuick _____mg

_____mg SQ _____ days per week.

Genotropin Pen 5 mg, 12 mg

_____mg SQ _____ days per week QTY____

Genotropin Mixer Device

Omnitrope:
5 mg/1.5 mL cartridges
10 mg/1.5 mL cartridges
5.8 mg/vial

_____mg SQ _____ days per week QTY___

Omnitrope Pen: 5 mg
10 mg

_____mg SQ _____ days per week QTY___

Saizen:
click.easy cartridge: 8.8mg
vial kits: 5mg, 8.8mg

_____mg SQ _____ days per week QTY___

cool.click2 device
cool.click device
easypod
one-click device

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

Patient/Parent/Guardian 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 KnippeRx, Inc. 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 _____ / _____ / _____