benevere PHARMACY

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beneverepharmacy.com

TODAY'S DATE: _____

☐ NEW PATIENT ☐ CURRENT PATIENT

HUMAN GROWTH HORMONE REFERRAL

PATIENT INFORMATION

Patient Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

DOB _____ SSN _____

Drug Allergies _____ ☐ Male ☐ Female

Patient Weight: _____ Height: _____

PRESCRIBER INFORMATION

Prescriber Name _____ DEA# _____

NPI# _____ Tax ID _____

Practice Name _____

Address _____ Suite _____

City _____ State _____ Zip _____

Office Phone _____ Fax _____

Office Contact _____

INSURANCE, MEDICARE OR MEDICAID INFORMATION

Primary Insurance _____ Secondary Insurance (if applicable) _____

Insurance Phone _____ Insurance Phone _____

COMPLETE OR FAX FRONT AND BACK COPIES OF INSURANCE, PRESCRIPTION AND/OR CO-PAY ASSISTANCE CARDS

CLINICAL INFORMATION

Primary Diagnosis: _____ ICD-10: _____

Secondary Endocrine Diagnosis/Treatment: _____

Has patient previously been on growth hormone? ☐ Yes ☐ No If yes, start date and product/dose: _____

☐ Patient has received injection training ☐ Physician's office to provide injection training ☐ Benevere Rx to coordinate injection training

DRUG NAME	DOSE/FREQUENCY	DIRECTIONS FOR USE	QTY	REFILLS
☐ Genotropin®	Pen: ☐ 5mg ☐ 12mg Mini-Quick: ☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.6mg ☐ 1.8mg ☐ 2.0mg	Inject _____mg subcutaneously daily		
☐ Humatrope®	Pen: ☐ 6mg ☐ 12mg ☐ 24mg Pre-Filled Syringe: ☐ 6mg ☐ 12mg ☐ 24mg Vial: ☐ 5mg	Inject _____mg subcutaneously daily		
☐ Increlex®	400mg vial	Inject _____mg subcutaneously daily shortly before or after a meal or snack (+/- 20 minutes).		
☐ Norditropin®	FlexPro®: ☐ 5mg ☐ 10mg ☐ 15mg Pre-filled Pen: ☐ 30mg/3ml	Inject _____mg subcutaneously daily		
☐ Nutropin®	10mg vial	Inject _____mg subcutaneously daily		
☐ Nutropin AQ®	NuSpin®: ☐ 5mg ☐ 10mg ☐ 20mg Pen: ☐ 5mg ☐ 10mg ☐ 20mg Vial: ☐ 10mg	Inject _____mg subcutaneously daily		
☐ Omnitrope®	Pen: ☐ 5mg ☐ 10mg Vial: ☐ 5.8ml	Inject _____mg subcutaneously daily		
☐ Saizen®	☐ 8.8mg Click Easy Device Vial: ☐ 5mg ☐ 8.8mg	Sig:		
☐ Tev-Tropin®	☐ 5mg Vial (Tjet Needle Free Device) ☐ 10mg	Sig:		
☐ Zorbtive®	8.8mg Vial	Inject _____mg subcutaneously daily		
☐ Lupron Depot-PED®	☐ 7.5mg ☐ 11.25mg ☐ 15mg ☐ 30mg	Sig:		

Deliver to: ☐ Patient's home ☐ MD's Office ☐ 1st dose to MD's Office, remaining refills to patient's home

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____