ENDOCRINOLOGY REFERRAL FORM

Updated July 2019

Patient Name _____ Today's Date_____ ☐ *NEW* Patient ☐ *CURRENT Patient*
DOB _____ Height _____ Weight _____ ☐ Male ☐ Female Preferred Language _____
Best Phone _____ Email _____
Street Address _____ Apt#_____ City _____ State _____ Zip _____
Ship to Patient at: ☐ Home ☐ Physician Office ☐ Work Address _____
Allergies _____
Current Medications including OTC's (*please fax a complete list*) _____

Please Fax Insurance Card(s) both sides
Insured's Name _____
Relation to Patient _____
Primary Insurance _____
ID# _____ Group # _____
Secondary Insurance _____
ID# _____ Group # _____

Ordering Prescriber _____
Office Contact _____
Street Address _____ Suite #_____
City _____ State _____ Zip _____
Tel _____ Fax _____
Email _____
License# _____
NPI# _____

ICD-10 Code ☐ _____ **Secondary ICD-10 Code** ☐ _____ Diagnosis _____
☐ **Yes** ☐ **No** Is Patient new to therapy? Date of diagnosis _____

PRESCRIPTION

☐ **GENOTROPIN** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **HUMATROPE** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **NORDITROPIN** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **OMNITROPE** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **SAIZEN** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **TEV-TROPIN** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **FORTEO®** (#1 pen) SIG: Inject 20mg SQ Daily QTY: 1pen with 30 needles Refill: _____

☐ **SAXENDA®** Multi-dose Pen ☐ 0.6 mg ☐ 1.2 mg ☐ 1.8 mg ☐ 2.4 mg ☐ 3 mg
SIG: Administer _____mg daily QTY: _____ Refill: _____

☐ **REPATHA® (EVOLOCUMAB) 140 mg/ml single-use prefilled SureClick® autoinjector**
SIG: Inject 140 mg subcutaneously every 2 weeks QTY: ☐ 1 month ☐ 3 months ☐ Other: _____ Refill: _____

☐ **THYROGEN® (THYROTROPIN ALFA FOR INJECTION)** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **CORTROSYN® (COSYNTROPIN FOR INJECTION)** Dose/Frequency/Route _____
SIG: _____ QTY: _____ Refill: _____

☐ **OTHER** _____ SIG: _____ QTY: _____ Refill: _____

LIST ANCILLARY SUPPLIES IF NEEDED _____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

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

My signature certifies that the person named on this form is my patient and that the information provided on this enrollment form is complete and accurate to the best of my knowledge. I certify this therapy to be medically necessary.

My signature authorizes The Pharmacy and its representatives to act as the agent to execute the insurance prior authorization process, assist the above named patient enroll into patient support programs, and appeal on behalf of prescriber and patient in the event of a prior authorization denial.

PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.