MedicoRx Specialty & HOME INFUSION PHARMACY

Growth Hormone
REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Considerations
Diagnosis (ICD 10) :____ ☐ Adult ☐ Pediatric

Drug Name	Strength/Directions for use	Notes
☐ Genotropin® Pen 5/5.8mg cartridge	☐ Norditropin® Pen/Cartridge 15mg	
☐ Genotropin® Pen 12/13.8 mg cartridge	☐ Nutropin AQ® Pen/Cartridge 10mg/2ml	
☐ Nordiflex ® Pen 5 mg	☐ Nutropin AQ® Pen/Cartridge 20mg/2ml	
☐ Nordiflex ® Pen 10mg	☐ Saizen® 5mg with Cool Click	
☐ Nordiflex ® Pen 15mg	☐ Saizen ® 8.8mg with Cool Click	
☐ Norditropin® Pen/Cartridge 5 mg	☐ Saizen ® One Click 8.8mg	

Dose: ____________________**mg** __________________**days per week or** ____________________**mg per kg per week**

Dispense ________ **month supply** **Refill** _______________**times through** _______/_______/_________

Administration training required: ☐ **Yes** ☐ **No**

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

____

Prescriber's signature (no stamps) if brand required check this ☐ DAW___ **Date**