

Growth Hormone - Adult Norditropin

CareFirst® BlueCross® BlueShield® and CareFirst® BlueChoice, Inc. Prescription Form

Please fax form to 1-866-546-2925 with a copy of Pt. insurance I.D. For questions please call 1-866-522-2486

Patient name _____ Phone _____

M.D. name _____

Address _____

M.D. DEA# _____ M.D. lisc# _____ N.P.I.# _____

City _____ State _____ Zip _____

Facility / Practice name _____

Patient DOB ____/____/____ Please check one: New Patient Order change

Address _____

Ins ID# _____ Group# _____

City _____ State _____ Zip _____

Allergies NKN Other (list): _____

Contact person _____ Phone _____ Fax _____

List any business days that your Facility / Practice will be closed: _____

DIAGNOSIS/STATEMENT OF MEDICAL MECISSITY

Primary ICD-9 Code: _____

- 1. Does the patient have adult-onset evidence of hypothalamic-pituitary disease? Y N
2. History of cranial irradiation? Y N
3. Documented childhood-onset growth hormone deficiency? Y N
4. Has the patient been evaluated for other endocrine disorders (e.g., thyroid deficiency)? Y N
5. Failed Stimulation Test Date #1: ____/____/____ Peak Value _____ Failed Stimulation Test #2 Date: ____/____/____ Peak Value _____
6. If patient has been on growth hormone, has the serum insulin-like growth factor 1 (IGF-1) been monitored? Y N
7. Is the patient currently on requested treatment? Y N If yes, how long on treatment? _____(months)
8. Has the patient failed Norditropin therapy in the past? Y N

Please submit a complete copy of recent history and physical.

NORDITROPIN® - "PREFERRED" ON FORMULARY

Y N Starter Kit: Includes NordiPen® delivery system, NordiPenMate®, auto insertion device, NovoFine® 31 Disposable needles, and allied injection materials.

Y N JumpStart Consent: The patient and I have agreed that if qualified, we would like to have a JumpStart shipment sent to patient prior to the completion of the insurance verification. We would like the patient to receive Norditropin by (date) ____/____/____

Y N Home Training Consent: I am requesting home nursing training for my patient to teach the administration of subcutaneous injections

Norditropin Nordiflex® ____x 5mg Pen/1.5ml Norditropin® cartridge ____x 5mg/1.5mL Cartridge, Nordipen® 5 delivery system NovoFine® 31 needles (31G 6 mm) ____ box of 100

Norditropin Nordiflex® ____x 10mg Pen/1.5ml Norditropin® cartridge ____x15mg/1.5mL Cartridge, Nordipen® 15 delivery system NovoFine® 30 needles (30G 8 mm) ____ box of 100

Norditropin Nordiflex® ____x 15mg Pen/1.5ml

Norditropin Nordiflex® ____x 30mg pen/3.0ml

Drug Name _____ Strength _____ QTY _____

Sig _____ Requested Duration _____ Refills _____

THIS PRESCRIPTION WILL BE FILLED GENERICALLY UNLESS THE PRESCRIBER WRITES 'daw' IN THE BOX BELOW.



Dispense As Written

Information on this form is accurate as of this date ____/____/____.

M.D. Signature _____