Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Avella Specialty Pharmacy | HGH Prescription Referral Form

Send your Rx to: | Choose Location

avella.com
If you have questions or concerns, please contact us.

Date Medication Needed: _____ **Ship To:** ○ Patient's Home ○ Prescriber's Office ○ Pick-up (store location): _____ Injection training by pharmacy? ☐

1: Patient Information

Patient Name: _____ **Birthdate:** _____ **Sex:** ○ Male ○ Female **Height:** _____ **Weight:** _____ ○ lbs. ○ kg.

Soc. Sec. #: _____ **Preferred Phone:** _____ **Known Allergies:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Alternate Caregiver Name: _____ **Preferred Phone:** _____

Insurance Information: Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical)

2: Prescriber Information

Provider Name: _____ **DEA#:** _____ **NPI#:** _____ **Tax ID#:** _____

Address: _____ **Phone:** _____ **Fax:** _____

City, State, Zip: _____ **Key Contact:** _____ **Phone:** _____

3: Diagnosis/Clinical Information | *Please FAX recent clinical notes, Labs, Tests, with the prescription to expedite the Prior Authorization*

Primary Diagnosis (check one) ○ **Adult** ○ **Pediatric**

_____ **ICD-10:** _____

Secondary Diagnosis:

_____ **ICD-10:** _____

Has patient previously been on growth hormone? ○ **Yes** ○ **No**

If yes, start date and product/dose: _____

Please attach information for Growth Disorder Diagnosis/other lab results:

- **Current history/physical and clinic notes**
- **GH stimulation test results**
- **Growth charts/velocity**
- **IGF-I results**
- **Bone age**

4: Prescription Information

Medication	Dose/Strength	Sig	Qty.	Refills
☐ **Genotropin®**	☐ **Cartridge:** ☐ 5mg ☐ 10mg ☐ **Mini-Quick:** ☐ 0.2mg ☐ 0.4mg ☐ 0.6mg ☐ 0.8mg ☐ 1.0mg ☐ 1.2mg ☐ 1.4mg ☐ 1.8mg	**Any other device used? (check one if applicable):** ☐ Adult ☐ Pediatric Diluent Amount: _____ Injection Volume: _____ Dose _____ mg _____ days/week Dose _____ mg/kg/wk Dispense _____ months supply Refill _____ times or through _____ (date) **Specific administration supply (gauge):** _____ Note to TN prescribers: Quantity must be written in both numerals and words (for example: 3 (three) doses)		
☐ **Humatrope®**	☐ **Cartridge:** ☐ 6mg ☐ 12mg ☐ 24mg ☐ **Vial:** ☐ 5mg			
☐ **Increlex®**	☐ 400mg/4ml vial (Note: maximum dose of 0.12 mg/kg SQ twice daily, injection should be administered shortly [20 min] before/after a meal/snack)			
☐ **Norditropin®**	☐ **FlexPro®:** ☐ 5mg ☐ 10mg ☐ 15mg ☐ **Prefilled Pen:** ☐ 30mg/3ml			
☐ **Nutropin®** (vial)	☐ 5mg ☐ 10mg			
☐ **Nutropin AQ**	☐ **NuSpin® Pen:** ☐ 5mg ☐ 10mg ☐ 20mg ☐ **Pen cartridge:** ☐ 10mg ☐ 20mg			
☐ **Omnitrope®**	☐ 5mg/1.5ml ☐ 5.8mg/vial ☐ 10mg/1.5ml			
☐ **Saizen®**	☐ 8.8mg Click Easy Cartridge ☐ **Vial:** ☐ 5mg ☐ 8.8mg			
☐ **Tev-Tropin®**	☐ 5mg Vial			
☐ **Zorbtive®**	☐ 8.8mg Vial			
☐ **Lupron Depot®**	☐ 7.5mg ☐ 11.25mg ☐ 15mg ☐ 30mg			
☐ **Pen Needles**	Size: Qty:			
☐ **Syringes**	Size: Qty:			

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

Patient Signature: _____ Date: _____

Prescriber Signature: Prescriber, please sign and date below

Dispense as written _____ Date _____ Substitution Permissable _____ Date _____

Pursuant to VA/OH/MO/VT law, only 1 medication is permitted per order form. Please use a new form for additional items.

# of Prescriptions: _____