Priority Health Pharmacy

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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.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.
PLEASE NOTE: The Pharmacy can only accept original prescription drug orders from patients, faxed prescriptions can be accepted only from the prescribing practitioners.