Growth Disorders

DIPLOMAT®

Phone: 877.977.9118
Fax: 866.376.1448
Insert Sales Contact Name (if known)

First-Time Fills: Use the manufacturer's Statement of Medical Necessity (SMN) Form (Digital form:Links to the SMN forms are provided below).
Subsquent Fills: Use this Growth Disorders enrollment form.

Patient Information

Patient name: _____ DOB: _____
Sex: ☐ Female ☐ Male SSN: _____
Language: _____ Wt: _____ ☐kg ☐lbs Ht: _____ ☐cm ☐in
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Phone: _____ Alternate: _____
Caregiver name: _____ Relation: _____
Local pharmacy: _____ Phone: _____
Insurance plan: _____ Plan ID: _____
Please fax a copy of front and back of the insurance card(s).

Prescriber + Shipping Information

Prescriber name: _____
NPI: _____
Address: _____
Apt/Suite: _____ City: _____ State: _____ Zip: _____
Contact: _____
Phone: _____ Alternate: _____
Fax: _____
Email: _____
If shipping to prescriber: ☐ First Fill ☐ Always ☐ Never

Clinical Information (Please fax all pertinent clinical and lab information)

Diagnosis ☐E23.0 (Hypopituitarism) ☐E23.1 (Drug-Induced Hypopituitarism) ☐E34.3 (Short Stature due to Endocrine Disorder)
☐Q87.1 (Congential Malformation Syndromes Predominantly associated with Short Stature)
☐Q96.9 (Turner's Syndrome) ☐R62.52 (Pediatric Short Stature) ☐ _____

Prior Therapy ☐ Yes ☐ No	Reason for Discontinuation of Therapy	Approximate Start Date	Approximate End Date

Comorbidities: _____
Concomitant Medications: _____
Allergies: ☐ NKDA ☐ Other: _____

Prescription	Directions	Strength		Quantity	Refill
☐ Genotropin® (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 31 G x 5/16" BD Ultra-Fine pen needles ☐ _____	☐ 5 mg ☐ 10 mg	Cartridge	_____	_____
	☐ 31 G x 5/16" BD Ultra-Fine pen needles ☐ _____	☐ 0.2 mg ☐ 0.4 mg ☐ 0.6 mg ☐ 0.8 mg ☐ 1 mg ☐ 1.2 mg ☐ 1.4 mg ☐ 1.8 mg ☐ 2 mg	Mini-Quick		
☐ Humatrope® (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 31 G x 5/16" BD Ultra-Fine pen needles ☐ _____	☐ 6 mg ☐ 12 mg ☐ 24 mg	Cartridge	_____	_____
	☐ 27 G x 1/2" BD needle with attached 1 mL syringe ☐ 27 G x 1/2" BD needle with separate 3 mL syringe ☐ _____	☐ 5 mg	Vial		
☐ Norditropin® (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 30 G x 1/3" Novofine needles ☐ _____	☐ 5 mg ☐ 10 mg ☐ 15 mg ☐ 30 mg	FlexPro®	_____	_____
☐ Nutropin AQ® (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 31 G x 5/16" BD Ultra-Fine pen needles ☐ _____	☐ 5 mg ☐ 10 mg ☐ 20 mg	Cartridge	_____	_____
	☐ 31 G x 5/16" BD Ultra-Fine pen needles ☐ _____	☐ 10 mg ☐ 20 mg	NuSpin®		
☐ Omnitrope® (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 31 G x 5/16" BD Ultra-Fine pen needles ☐ _____	☐ 5 mg/1.5 mL ☐ 10 mg/1.5 mL	Cartridge	_____	_____
	☐ Mixing: 25 G x 5/8" needle with 3 mL Leur-Lok syringe Injecting: 27 G x 1/2" BD needle with 1 mL syringe ☐ _____	☐ 5.8 mg	Vial		
☐ Saizen® (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 27 G x 1/2" BD needle with attached 1 mL syringe ☐ 27 G x 1/2" BD needle with separate 3 mL syringe ☐ _____	☐ 8.8 mg	Easy Click Cartridge	_____	_____
		☐ 5 mg ☐ 8.8 mg	Vial	_____	_____
☐ Zomacton™ (somatropin)	Inject _____ subcut once daily _____ times per week ☐ 27 G x 1/2" BD needle with attached 1 mL syringe ☐ 27 G x 1/2" BD needle with separate 3 mL syringe ☐ _____	☐ 5 mg ☐ 10 mg	Vial	_____	_____

*Sufficient quantity of needles and syringes will supplied with medication, as applicable.

Per state-specific law, prescriptions will be dispensed as generic, if applicable, unless notated otherwise: _____

Prescriber's Signature: _____ Date: _____

I authorize Diplomat Pharmacy, Inc. and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to Diplomat Pharmacy, Inc.