

# GROWTH HORMONE DEFICIENCIES Referral Form

Fax to: (844) ReferRx  
733-3779

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.

Please contact your Valeda team if you have any questions and/or concerns at (844) 698-2533

Date Medication Needed: \_\_\_\_\_ Ship To: \_\_\_\_\_ Patient's Home \_\_\_\_\_ Prescriber's Office \_\_\_\_\_

## 1 Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_ Preferred Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Home / Mobile (circle one)  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## Alternate Caregiver Information

Alternate Caregiver Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

## 2 Prescriber Information

Provider Name: \_\_\_\_\_ NPI#: \_\_\_\_\_  
Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Tax ID#: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## Practice Contact Information

Practice Contact: \_\_\_\_\_  
Contact Phone: \_\_\_\_\_ Contact Email: \_\_\_\_\_

## 3 Clinical / Diagnosis Information

PLEASE FAX (1) Therapy regimen(s) / schedule, (2) last clinical notes and (3) lab values/scans -- (current and past)

Sex: Male Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. kg. (circle one)

Diagnosis: \_\_\_\_\_

ICD-10: (required for Medicare B billing) \_\_\_\_\_

Epiphysis open? ☐ Yes ☐ No Bone age: \_\_\_\_\_

Growth velocity: \_\_\_\_\_ Date \_\_\_\_\_

## Provocative Growth Hormone Stimulation Tests:

Agent: \_\_\_\_\_ Peak value: \_\_\_\_\_ Date: \_\_\_\_\_

Agent: \_\_\_\_\_ Peak value: \_\_\_\_\_ Date: \_\_\_\_\_

Previously Tried Therapy: \_\_\_\_\_

Reason for D/C: \_\_\_\_\_

## Known Allergies

Allergy: \_\_\_\_\_

Severity: \_\_\_\_\_ Rescue Medication? Yes / No (circle one)

## 4 Insurance Information

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

## 5 Prescription Information

STRENGTH / DIRECTIONS (SIG):

	Qty:	Refills:
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

Prescriber Signature: \_\_\_\_\_ Prescriber, please sign and date below

PHYSICIAN SIGNATURE REQUIRED

Dispense as written \_\_\_\_\_ Date \_\_\_\_\_ Substitution Permissible \_\_\_\_\_ Date \_\_\_\_\_

I authorize Valeda RX and its representatives to act as an agent to initiate and execute the insurance prior authorization process.

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do 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. 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: \_\_\_\_\_