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: Home / Mobile (circle one)

Address: _____

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.

# of Prescriptions: _____