MORRISTOWN PHARMACY

ENDOCRINOLOGY REFERRAL FORM

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Tel: 973-998-0287 | Fax: 973-998-0288

Proudly serving New Jersey, New York, Pennsylvania, Ohio, Massachusetts, Arizona & Rhode Island

Today's Date _____ Anticipated Start Date _____

☐ NEW PATIENT ☐ CURRENT PATIENT

Last updated: May 2017

Patient Name First Name Middle Name Last Name DOB _____ Weight _____ ☐ Male ☐ Female

Street Address _____ Apt # _____ City _____ State _____ Zip _____

Daytime Tel _____ Evening Tel _____ Cell _____ Email _____

Ship to Patient at ☐ Home ☐ Work **OR** Patient will pick up at ☐ Physician Office ☐ Pharmacy Date Needed _____

Primary ICD-10 Code _____ Secondary ICD-10 Code _____ Is patient new to therapy? ☐ No ☐ Yes Date of Diagnosis _____

Insured's Name _____ Relation to Patient _____ Eligible for Medicare ☐ Yes ☐ No If yes, Medicare# _____

Prescription Card ☐ Yes ☐ No If Yes, Carrier _____ Tel _____ Fax _____ Policy/Group# _____

Bin# _____ Pcn# _____ RXID# _____ RX Group# _____

Prescriber's Name _____ Office Contact _____

Street Address _____ Suite # _____ City _____ State _____ Zip _____

Tel _____ Fax _____ Email _____

License# _____ NPI# _____ UPIN# _____ DEA# _____

PRESCRIPTION

PLEASE ATTACH COPIES OF PATIENT'S INSURANCE CARDS

GENOTROPIN Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

HUMATROPE Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

NORDITROPIN Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

OMNITROPE Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

SAIZEN Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

TEV-TROPIN Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

FORTEO® (#1 pen) Inject 20mg SQ Daily Qty 1pen w/30 needles Refill x _____

REPATHA® (EVOLOCUMAB) ☐ 140 mg/ml single-use prefilled SureClick® autoinjector
SIG: Inject 140 mg subcutaneously every 2 weeks
QTY: ☐ 1 month supply ☐ 3 month supply ☐ Other _____ Refills _____

THYROGEN® (THYROTROPIN ALFA FOR INJECTION)
Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

CORTROSYN® (COSYNTROPIN FOR INJECTION)
Dose/Frequency/Route _____
Sig _____
Qty _____ Refills _____

OTHER _____
Sig _____
Qty _____ Refills _____

PLEASE LIST ANCILLARY SUPPLIES IF NEEDED
_____
_____

☐ **ENROLL IN NURSE TRAINING / MANUFACTURER PROGRAM**

Prescriber's Signature (signature required. NO STAMPS) _____ **Date** _____