Statement of Medical Necessity

Please fill out completely and fax to (888) 689-9892
Call (855) 277-2488

Patient Name (First and Last): ______________________________ DOB: _____ /_____ /_______

Address: ______________________________ City: ________________ State: _______ Zip: ________

Phone: (   ) ________________ Alternate Phone: (   ) ________________ Gender: Male Female

Email: ______________________________ Patient SSN: ______________________________

Allergies: ____

DIAGNOSIS

Please check the ICD-10 diagnosis code that applies. (Icd-9 codes are in parentheses.)

GHD (Pediatric and Adult)

- E23.0 Panhypopituitarism (253.2)
- E23.1 Iatrogenic Hypopituitarism (253.7)
- E23.0 Growth Hormone Deficiency (253.3)

R62.52 **Idiopathic Short Stature** - 2.25 SDS (783.43)

SGA:

- R62.52 Short Stature/Growth Failure (783.43), plus
- P05.00 Small for Dates (764.00) or
- P05.9 Intrauterine Growth Retardation, Unspecified (764.90)

Q87.1 **Prader-Willi Syndrome** (759.81)

Q96.9 **Turner Syndrome** (758.6)

ICD-10 Code: ________________

PRESCRIPTION

Drug:

Omnitrope ® 5.8mg Vial (NDC 0781-4004-36)

Each vial contains 17.4iu - Once Diluted = 10iu/mL

For Vial

3cc Syringe with 18G 1" needle (for mixing)
Alcohol preparation pad X 2

Please remember to indicate the quantity and type of needles that should be shipped to the patient.
(Needles are sold separately and may require a separate prescription in some state).

Syringes for Administration:	Quantity
insulin syringe 31G 5/16"	________
1mL 27G 1/2"	________
Other: ________________	________

Ancillary supplies:
days' supply ______________

Vial Dose: _________ unit/Day _________ days/week **Dispense:** _________ vials **Refills:** _________

Once Diluted = 10iu/mL Discard: 21 days after dilute

PHYSICIAN CERTIFICATION

I certify that the above therapy is medically necessary and that the information provided is accurate to the best of my knowledge. By my signature I also acknowledge that I have obtained the patient's authorization to release the above information and such other information as may be required by Compounding Pharmacy of America and its employees or agents to assist in the litigating or continuing Omnitrope therapy. I appoint CPA, on my behalf, to convey this prescription to the dispensing pharmacy, Compounding Pharmacy of America (CPA). I further certify that (a) any service provided through CPA on behalf of any patient is not made in exchange for any express or implied agreement or understanding that I would recommend, prescribe, or use Omnitrope or any other CPA product or service for anyone, and (b) my decision to prescribe Omnitrope was based solely on my determination of medical necessity as set forth herein, and that (c) I will not seek reimbursement for any medication for any medication or service provided by or through CPA from any government program or third-party insurer.

Print Name: ____________________ **Practice:** ________________ **Date:** ____________ **DEA #:** __________

Address: ____________________ **City:** ________________ **State:** ____________ **Zip:** ______________

Office Contact : ____________________ **Phone:** ____________________ **Fax:** ____________________

Physician Provider / Tax ID # : ____________________ **Physician Provider / NPI # :** ____________________

If NP or PA, under direction of Dr.: ____________________ **Dispense as written:** ____________________

Signature★: ______________________________

★ This form cannot be processed without prescribing physician's full and usual signature. Actual signature is required – no stamps.

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(office) 855-277-2488 (fax) 888-689-9892