



Serostim[®] Referral Fax to 866-406-4215

Customer Service: 866-406-4209

MEDICA[®]

Patient Information Please type or print clearly.	Name		
	Address		
	City	State	ZIP Code
	Date of Birth		
	Home Phone w/area code		Work Phone w/area code
Insurance Information <input type="checkbox"/> Major Medical <input type="checkbox"/> Rx Benefit Please attach a copy of card(s) if possible.	Primary Insurer		
	Cardholder		Date of Birth
	Cardholder ID #		Group #
	RxCARD ID #	RxBIN #	RxGroup #
	Phone w/area code		Fax w/area code
Medical Assessment	Diagnosis		
	Weight Loss _____ Over the Duration of _____ Months		Current Weight
	Medical History		
	Allergies		
Prescription To be valid, prescription must be faxed from physician's office. Facsimile not valid for C-II prescriptions.	Serostim (somatropin) Injection		
	<input type="checkbox"/> Dispense 4 mg vial SIG: Mix and inject 4 mg SC once a day <input type="checkbox"/> Dispense 5 mg vial SIG: Mix and inject 5 mg SC once a day <input type="checkbox"/> Dispense 6 mg vial SIG: Mix and inject 6 mg SC once a day <input type="checkbox"/> Dispense _____ mg vial SIG: _____ Quantity _____ Refill x _____ Therapy Start Date _____		
Physician Certification <input type="checkbox"/> Please acknowledge receipt of this fax.	I certify that the above therapy is medically necessary and the information on this form is accurate to the best of my knowledge.		
	MD Signature (required)		Date
	Print MD Name		UPIN
	Form Faxed by		DEA #
	Address		
	City	State	ZIP Code
Phone w/area code		Fax w/area code	

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