

Health New England
Medication Request Form (MRF) /Prescription Request
Zorbtive® (somatropin)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Zorbtive®. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

J-code = J2941; unit = 1mg (if administered in physicians office, not for self administration)

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
Patient Cell Phone #: () -	Specialty:
Patient HNE ID#:	NPI #:
Patient Date of Birth:	HNE Provider #:
Allergies:	DEA #:
	Telephone #: () -
	Fax #: () -

Drug Information

Requested Drug/Strength/Form: Zorbtive®		
Dose, Directions, and length of treatment (please be specific): NOTE: HNE will provide up to one 4-week course of treatment per rolling year with dose not to exceed 8mg daily.	Quantity (per month):	Refills:
Physician Signature:	Date:	
Indication: <input type="checkbox"/> Short Bowel Syndrome		
Documentation of Medical Criteria: <input type="checkbox"/> Patient is on specialized nutritional support. <input type="checkbox"/> Daily dose of Zorbtive will be equal to or less than 8mg daily. <input type="checkbox"/> Patient is 18 years of age or older.		