Zarina Pharmacy
SPECIALTY & INFUSION

Precocious Puberty

Fax: 832-886-4298 Phone: 832-886-4296 zarinapharmacy.com

Need By Date: _____ Ship To: ☐ Patient ☐ Office ☐ Other _____ Fax Copy: ☐ Rx Card Front/Back ☐ Clinical Notes ☐ Medical Card Front/Back

Patient Information

Patient Name	
Address	
City State ZIP	
Main Phone	Alternate Phone
Social Security #	
Date of Birth	☐ Female ☐ Male

Prescriber Information

Prescriber Name		
Address		
City State ZIP		
Phone	Fax	
Contact Person		
DEA #	NPI #	License #

Clinical Information

Diagnosis		ICD-10
Bone Age	Growth Velocity	
Weight ☐ kg ☐ lbs	Height ☐ ft ☐ in	Stim #1: _____ / _____ / _____ ☐ Pass ☐ Fail Stim #2: _____ / _____ / _____ ☐ Pass ☐ Fail
LH Level/Date	FSH Level/Date	
Drug Allergies		Status: ☐ New ☐ Restart ☐ Continuing

To expedite prior authorization service, please attach supporting clinical notes, lab testing values, and scans.

Prescription Information			Qty	Refills
☐ Fensolvi®	☐ 45 mg Kit	Please contact Fensolvi Total Solutions HUB at 1-866-Fensolvi (1-866-336-7658) to complete the Patient Enrollment Form		None
☐ Lupron Depot-Ped (4 Week Supply)	☐ 7.5 mg Kit (Weight: 25 kg or less) ☐ 11.25 mg Kit (Weight >25-37 kg) ☐ 15 mg Kit (Weight:>37 kg)	Inject _____ mg intramuscularly every 4 weeks	1 Kit	_____
☐ Lupron Depot-Ped (12 Week Supply)	☐ 11.25 mg Kit ☐ 30 mg Kit	Inject _____ mg intramuscularly every 12 weeks	1 Kit	_____
☐ Supprelin® LA	☐ 50 mg Kit	Implant surgically subcutaneously every 12 months as directed by doctor	1 Kit	None
☐ Other				

By signing this form, you are authorizing BioPlus Specialty Pharmacy and its employees to serve as your designated agent in submitting clinical and other required information to third party payers with respect to this prescription and any refills or continuation of the same medication and dose for this patient. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee you should not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.

Prescriber's Signature (no stamps) **Substitution Permitted** **Date** **Prescriber's Signature** (no stamps) **Dispense As Written** **Date**