



3200 Highlands Parkway SE Suite 300 Smyrna, GA 30082 • 1-866-874-0633 • www.pshpgeorgia.com

Dear Provider,

Peach State Health Plan has made a decision to position TEV-TROPIN as its preferred Growth Hormone product. **The effective date of this change is 11/15/2011.**

We ask for your cooperation in making this transition as seamless as possible for your patients. Please fill out the enclosed enrollment form and fax it back to Caremark. Please be assured that training on the Needle-Free T-jet device will be provided by **Growth Solutions** based on patient availability. Here's what else you can expect.

- If you have a Peach State member currently on growth hormone therapy, and you have not sent a new enrollment form, a Caremark representative will be visiting your office to request a prescription order for TEV-TROPIN.
- The new form will automatically extend authorization for growth hormone treatment for your patient out to one year, unless the patient is close for consideration of discontinuing treatment.
- With receipt of the order, **Growth Solutions** will assume responsibility for training. Growth Solutions is a support system of nurses and insurance advisors that are available to assist with the conversion. Support services include a free home training visit for each patient to teach them how to prepare and inject TEV-TROPIN. The number to reach Growth Solutions is: 866-838-8767. (Please note that Growth Solutions will not be able to schedule training if the patient is not able to be reached.)

**If you choose not to make the change, the current authorizations for non-preferred agents will terminate, and new authorization requests will need to be submitted by your office. The new authorization will need to include clinical justification for non-preferred growth hormone.**

Thank you in advance for assisting us with these changes, and we appreciate your prompt response. We can be reached at 800-514-0083 option 2.

Sincerely,

Peach State Health Plan

**CONVERSION<sup>®</sup> ENROLLMENT FORM**  
**TEV-TROPIN<sup>®</sup> [somatropin (rDNA origin) for injection]**

**Phone: 1-800-514-0083 Option #2**  
**Fax to: 1-866-374-1579**

<b>Patient/Parent/ Guardian</b>	Patient Name:	DOB:	<input type="checkbox"/> M <input type="checkbox"/> F	
	Patient Address:	City:	ST:	ZIP:
	Parent/Guardian Name:	Home Phone #:	Work Phone #:	
	Email Address:	Cell Phone #:		
Okay to contact Parent/Guardian by phone or email <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Provider/ Physician</b>	Name:	Hospital or Clinic/Contact Name/Phone and Ext. #:		
	Address:	City:	ST:	ZIP:
	Phone #:	Fax:	NPI #:	DEA #:

**Physician signature REQUIRED to order TEV-TROPIN<sup>®</sup>, Tjet<sup>™</sup>, and Home-Based Injection Training.**

<b>Prescription</b>	<input type="checkbox"/> TEV-TROPIN <sup>®</sup> 5 mg vial with ancillary supplies: <input type="checkbox"/> 30 day supply <input type="checkbox"/> Refill: x _____	
	<input type="checkbox"/> <b>Manual Injection</b> <input type="checkbox"/> <b>Request Inject-Ease<sup>®</sup></b> <b>Dose:</b> _____ mg/injection _____ days per week. <b>Dilute:</b> 5 mg TEV-TROPIN <sup>®</sup> vial with _____ mL/diluent. <b>Inject:</b> _____ mL/ injection.  Diluent and injection needles/syringes determined by fulfillment pharmacy unless otherwise indicated. B-D syringes recommended for proper fit for <b>Inject-Ease<sup>®</sup></b> . Preferred diluent syringe/needle _____ Preferred injection syringe/needle _____	<input type="checkbox"/> <b>Tjet<sup>™</sup> Injection Device</b> (supplies to include: syringe heads, vial adapters, Bact. NaCl practice vial). <b>Sig:</b> Administer prescribed dose as directed. <b>Refill:</b> PRN  <b>TEV-TROPIN<sup>®</sup> sig when using Tjet<sup>™</sup>.</b> Dilute 5 mg TEV-TROPIN <sup>®</sup> vial with 1 mL/diluent. <b>Using Tjet<sup>™</sup> device, inject</b> _____ mg (must be in even increments of 0.05 mg) _____ days per week.

<b>Injection Training</b>	<input type="checkbox"/> <b>Check if Ordering Home-Based Training</b> (Skilled nurse visit for first dose instruction on TEV-TROPIN <sup>®</sup> administration for patient.) <b>Injection Training will be/has been conducted by the physician's office?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <b>Date:</b> _____
---------------------------	---

<b>Physician Authorization</b>	<b>Prescriber's Signature</b>	<b>Date</b>
	(Practitioner required license # _____) <b>X</b> _____	_____
	DEA#: _____ NPI# _____	
	If NP or PA, under direction of Dr. _____ License # _____	
	<b>Print Prescriber's name:</b>	_____
	Prescriber certifies this is his/her full and usual signature.	

**PLEASE NOTE:** Completion of this form is not a guarantee of approval. Eligibility verification is the responsibility of the provider. Fax Confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the attached material is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error please notify us immediately by telephone at: