

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Growth Hormones: Prior Authorization Request Form: Please respond.

- Please complete the attached Growth Hormones Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Growth Hormones

Somatropin (Tev-Tropin®, Genotropin®, Humatrope®, Norditropin®, Nutropin®, Saizen®, Serostim®, Zorbtive®). The use of somatropin for AIDS wasting or cachexia should only be considered after the patient has failed other traditional therapies (e.g., dronabinol). Off-label use for non-FDA-approved indications is strongly discouraged.

Growth failure in children may result from

1. inadequate endogenous growth hormone secretion OR
2. associated with chronic renal insufficiency up until the time of renal transplantation OR
3. Prader-Willi syndrome;
4. short stature associated with Turner Syndrome (in patients who may have open epiphysis
5. short stature or growth failure SHOX deficiency whose epiphysis are not closed.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form



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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Growth Hormones Criteria

- Please indicate agent requested:
 Tev-Tropin® Genotropin®
 Humatrope® Norditropin®
 Nutropin® Nutropin AQ®
 Saizen® Serostim®
 Zorbtive®
- Please indicate the dispensing location:
 the pharmacy
 the physician's office, incident to a physician's service
 other: _____
- Please indicate ICD-9 code supporting the necessity for the requested drug. This question must be completed.
 ICD-9: _____
- Indicate specialty of physician prescribing or recommending growth hormone treatment (must be appropriate to diagnosis)
 Infectious Disease Gastroenterology
 Endocrinology
 Other _____
- Provide indication for growth hormone treatment:
 Replacement of endogenous growth hormone in patients w/ adult growth hormone deficiency who meet both of the following criteria: Subnormal response to a standard growth hormone stimulation test (peak growth hormone <5 mcg/L), AND Growth Hormone deficiency as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma; OR who had growth hormone deficient during childhood (confirmed as an adult before replacement therapy is initiated)
 Adults w/ AIDS wasting or cachexia with concomitant antiretroviral treatment OR Adults with short bowel syndrome
 Children (<18 years) w/ growth failure
 other: _____
- If diagnosis is for AIDS wasting or cachexia, has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance to two of the following therapies: megestrol, dronabinol, oxandrolone, mirtazapine?
 Yes No

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____