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

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

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

1 Please indicate agent requested:
- ☐ Tev-Tropin®
- ☐ Humatrope®
- ☐ Nutropin®
- ☐ Saizen®
- ☐ Zorbtive®
- ☐ Genotropin®
- ☐ Norditropin®
- ☐ Nutropin AQ®
- ☐ Serostim®

2 Please indicate the dispensing location:
- ☐ the pharmacy
- ☐ the physician's office, incident to a physician's service
- ☐ other: ....

3 Please indicate ICD-9 code supporting the necessity for the requested drug. This question must be completed.
- ☐ ICD-9: ....

4 Indicate specialty of physician prescribing or recommending growth hormone treatment (must be appropriate to diagnosis)
- ☐ Infectious Disease
- ☐ Gastroenterology
- ☐ Endocrinology
- ☐ Other ....

5 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: ....

6 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): ______________________

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Prescriber's signature:______________________ Date:______________

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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