

Growth Hormone Preauthorization Physician Fax Form

Only the prescriber may complete this form for prospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically at MedicalPolicy.NebraskaBlue.com.*

What is the priority level of this request?

- ☐ Standard review - Completed within 15 calendar days of receipt.
- ☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient Information

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:
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Insurance Information

BCBS ID Number:	Group Number:
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Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip Code:	Phone Number:		Secure Fax Number:	

Preauthorization Information

This request is for a(n)..... ☐ Child ☐ Adult

Growth hormone requested: _____ Daily dose requested: _____ Patient weight: _____

Patient's diagnosis to be treated with requested medication (ICD 10 code): _____

If requested product is not Norditropin®, has the patient tried and failed Norditropin®?..... ☐ Yes ☐ No

If no, please list any contraindications, drug allergies, or adverse effects to treatment with Norditropin®: _____

Is this a preauthorization request for renewal of growth hormone?..... ☐ Yes ☐ No

If yes, when was the growth hormone therapy started? _____ (Please proceed to renewal section)

Children: INITIAL Request Section

Patient height (cm or inches): _____ Height SD below the mean: _____ Patient is at the _____ percentile for age

Growth velocity (cm/year): _____ Bone age: _____

Results of TWO GH stimulation tests (list test and results): _____

1. If diagnosis of chronic renal insufficiency, is the patient post-transplant?..... ☐ Yes ☐ No
Creatinine clearance (mL/min): _____
2. Is the deficiency the result of congenital, genetic, or acquired causes (i.e., pituitary disease or tumor, hypothalamic disease, surgical damage, etc)?..... ☐ Yes ☐ No
3. If diagnosis is AID/HIV wasting syndrome or cachexia, is the patient receiving treatment with antiretroviral agents?..... ☐ Yes ☐ No
4. If diagnosis is short bowel syndrome, is the patient dependent on specialized nutritional support?..... ☐ Yes ☐ No

Children: RENEWAL Request Section

1. Has the diagnosis of GHD, AIDS/HIV wasting, chronic renal insufficiency, PWS, Turner's syndrome, SHOX, Noonan syndrome, SGA, or idiopathic short-stature been established in the past?..... ☐ Yes ☐ No
2. Growth velocity (cm/year): _____ 3. Epiphyses are open as determined by X-ray?..... ☐ Yes ☐ No
4. If diagnosis is chronic renal insufficiency, is the patient dependent on specialized nutritional support?..... ☐ Yes ☐ No

Adult: INITIAL Request Section

Results of TWO GH stimulation tests and IGF-I/GFBP-3 studies (list test and results): _____

1. Is the deficiency the result of congenital, genetic, or acquired causes (i.e., pituitary disease or tumor, hypothalamic disease, surgical damage, etc)?..... ☐ Yes ☐ No
2. If diagnosis is AID/HIV wasting syndrome or cachexia, is the patient receiving treatment with antiretroviral agents? ☐ Yes ☐ No
3. If diagnosis is short bowel syndrome, is the patient dependent on specialized nutritional support?..... ☐ Yes ☐ No

Adult: RENEWAL Request Section

1. Has the diagnosis of GHD, AIDS/HIV wasting been established in the past?..... ☐ Yes ☐ No
2. Is the patient's IGF-I concentration in the normal range for age and sex?..... ☐ Yes ☐ No

Please fax or mail this form to:

Prime Therapeutics
Pharmacy Department - UM
1919 Aksarben Drive • PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726**Phone:** 877-999-2374

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