



Prior Authorization Form
GROWTH HORMONES

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Genotropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-Tropin, Zorbtive, Increlex

Drug Strength _____ Quantity _____ Refill x _____ months

Instructions _____

Physician's signature _____ Provider NPI: _____ MD# _____

Date: _____ Date medication needed _____

Patient Information

Patient's name, address, City, State, Zip, phone #, ID#, DOB

Prescriber Information

Prescribing physician, Office address, City, State, Zip, Office contact, Office #, Fax#

Upon approval, delivery is available. Complete section below.

- No Delivery Requested, Delivery Requested, Member Pick up at pharmacy, Physician's office, Patient's home

A copy of the prescription must accompany the medication request

1. PHYSICIAN'S SPECIALTY (required) Endocrinology, Other (specify all)

2. DIAGNOSIS FOR DRUG REQUESTED

- Growth hormone deficiency in adults, Chronic Renal Insufficiency, Prader Willi Syndrome (PWS), AIDS Wasting Syndrome, Growth Failure in children with IGF-1 deficiency, Growth hormone deficiency in Children, Small for Gestational Age, Turner Syndrome, Idiopathic Short Stature, Dwarfism-Noonan Syndrome, Dwarfism SHOX Deficiency, Growth Failure in children with GH deletion and resistance to GH

3. PATIENT INFORMATION:

Table with fields: Last office visit, Bone Age, IGF-1, Height SD, Provocative Testing Agent, Height, Chronological Age, Growth Velocity, Response, Date of Test

Please include any other pertinent history for the diagnosis, such as: Clinical evaluation notes, Laboratory tests (FSH, LH, TSH, ACTH), Growth Charts and list any other pertinent medication history in the section below

Table with columns: Drug name, Dates, Duration

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL