FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Growth Hormones Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the medication requested below:

❑ Genotropin ❑ Norditropin FlexPro ❑ Omnitrope ❑ Zomacton
❑ Humatrope ❑ Nutropin AQ Nuspin ❑ Saizen

Select the diagnosis below:

❑ Growth hormone deficiency in children
❑ Growth hormone deficiency in adults
❑ Growth failure associated with chronic kidney disease (CKD)
❑ Idiopathic short stature in children
❑ Noonan syndrome
❑ Prader-Willi syndrome
❑ Short stature homeobox containing gene (SHOX) deficiency
❑ Small for gestational age
❑ Turner syndrome
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Is the requested medication recommended by an endocrinologist? ❑ **Yes** ❑ **No**

For growth failure associated with chronic kidney disease: Is the requested medication recommended by a nephrologist or endocrinologist? ❑ **Yes** ❑ **No**

For growth hormone deficiency in children, answer the following:

Does the patient have a subnormal serum insulin-like growth factor-1 (IGF-1) level? ❑ **Yes** ❑ **No**

Does the patient have a growth velocity less than or equal to 5 cm/year after 2 years of age? ❑ **Yes** ❑ **No**

Document the patient's bone age: _____

Does the patient have an abnormal response from provocative testing of one of the following: clonidine, insulin-induced hypoglycemia test, levodopa? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have annual clinical re-evaluation by the treating endocrinologist? ❑ **Yes** ❑ **No**

Does the patient have normalization of IGF-1? ❑ **Yes** ❑ **No**

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For growth hormone deficiency in adults, answer the following:

Does the patient have diagnostically confirmed growth hormone deficiency? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have annual clinical re-evaluation by the treating endocrinologist? ❑ **Yes** ❑ **No**

Does the patient have normalization of IGF-1? ❑ **Yes** ❑ **No**

For growth failure associated with chronic kidney disease, answer the following:

For Reauthorization:

Does the patient have annual clinical re-evaluation by the treating endocrinologist or nephrologist? ❑ **Yes** ❑ **No**

Does the patient have a history of renal transplant? ❑ **Yes** ❑ **No**

For idiopathic short stature, answer the following:

Does the patient have idiopathic short stature as defined by a height standard deviation score (SDS) of less than or equal to 2.25? ❑ **Yes** ❑ **No**

Document the patient's growth velocity: _____

For Reauthorization:

Does the patient have annual clinical re-evaluation by the treating endocrinologist? ❑ **Yes** ❑ **No**

Does the patient have an increase in growth velocity from baseline? ❑ **Yes** ❑ **No**

For Noonan syndrome, Prader-Willi syndrome, Turner syndrome, or short stature homeobox-containing gene (SHOX) deficiency, answer the following:

For Reauthorization:

Does the patient have annual clinical re-evaluation by the treating endocrinologist? ❑ **Yes** ❑ **No**

For small for gestational age, answer the following:

Is there clinical documentation of no catch-up growth by 2 to 4 years of age? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have annual clinical re-evaluation by the treating endocrinologist? ❑ **Yes** ❑ **No**

Does the patient have increase in growth velocity from baseline? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.