Prior Authorization Request Form for Growth Hormones (somatropins)

Member Information

Patient Name ____________________________

Cardholder ID ___________________________

Date of Birth ____________________________

Address ________________________________

City, State Zip ___________________________

Phone Number ____________________________

Provider Information

Provider Name _____________________________

DEA Number ______________________________

Address ___________________________________

City, State and Zip ___________________________

Phone Number ______________________________

FAX Number _______________________________

Pharmacy Information

Pharmacy Name___________________Address__________________Phone______________________

Criteria for Approval:

1. Growth hormone agent requested: *Check one (please include strength):*
   - ☐ Genotropin_____ ☐ Humatrope_____ ☐ Norditropin_____ ☐ Nutropin_____
   - ☐ Nutropin AQ_____ ☐ Nutropin Depot_____ ☐ Saizen_____
2. Is the patient 18 years of age or older? Yes ☐ No ☐
3. Has the patient been diagnosed with any of the following? *Check all that apply:*
   - ☐ Adult-onset hypothalamic-pituitary disease
   - ☐ Chronic renal insufficiency/renal failure
   - ☐ Classic growth hormone deficiency
   - ☐ Prader-Willi Syndrome
   - ☐ Turner's Syndrome
4. Has the patient been on a growth hormone for the previous 6 months? Yes ☐ No ☐
5. Does the patient have more than 2 standard deviations below the mean height for normal childhood or more than 1.5 standard deviations below the mid-parental height? Yes ☐ No ☐
6. Has the patient been evaluated for other causes of growth failure? Yes ☐ No ☐
7. Has the patient exhibited a decrease in hypothalamic-pituitary function? Yes ☐ No ☐
8. Has the patient had a height increase within the previous 6 months? Yes ☐ No ☐
9. Does the patient display any of the following requirement for approval: *Check all that apply:*
   - ☐ Poor growth velocity (i.e., < 5 cm per year)
   - ☐ Closed or fused epiphyses
   - ☐ Renal Transplant
   - ☐ Being small for gestational age (i.e., 2 standard deviations below normal)
   - ☐ Delayed bone age in relation to chronological age

Provider Signature ____ Date ________________________

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received____

Reference Number____

Approved / Denied (Circle One) by _____________________________ Date________________________

Date/Time Returned to Provider____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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