



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

Prescriber Information

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

Upon approval, delivery is available. Complete section below.

- | | |
|--|---|
| <input type="checkbox"/> No Delivery Requested | <input type="checkbox"/> Delivery Requested |
| <input type="checkbox"/> Member Pick up at pharmacy if benefit available | <input type="checkbox"/> Physician's office <input type="checkbox"/> 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

- | | |
|--|--|
| <input type="checkbox"/> Growth hormone deficiency in adults
<i>Type of onset:</i> <input type="checkbox"/> Adult onset <input type="checkbox"/> Childhood onset
<input type="checkbox"/> Chronic Renal Insufficiency
<input type="checkbox"/> Prader Willi Syndrome (PWS)
<input type="checkbox"/> AIDS Wasting Syndrome <input type="checkbox"/> Short Bowel Syndrome
<input type="checkbox"/> Growth Failure in children with IGF-1 deficiency
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Growth hormone deficiency in Children
<input type="checkbox"/> Small for Gestational Age: Birth Weight _____ GA _____
<input type="checkbox"/> Turner Syndrome
<input type="checkbox"/> Idiopathic Short Stature
<input type="checkbox"/> Dwarfism-Noonan Syndrome <input type="checkbox"/> Dwarfism SHOX Deficiency
<input type="checkbox"/> Growth Failure in children with GH deletion and resistance to GH |
|--|--|

3. PATIENT INFORMATION:

Last office visit:	Height:	Weight:
Bone Age:	Chronological Age:	Date of Test:
IGF-1:	Ref. Range:	Growth Velocity (cm/year):
Height SD:		
Provocative Testing Agent:	Response:	Date of Test:
Provocative Testing Agent:	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

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

**FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**