

US Family Health Plan Growth Hormone Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program (USFHP).

MAIL ORDER	If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here <input type="checkbox"/>	RETAIL	If the prescription is to be filled at a retail pharmacy, check here <input type="checkbox"/>
	<ul style="list-style-type: none"> The completed form and the prescription may be faxed to 1-617-562-5296 OR The patient may attach the completed form to the prescription and mail it to: Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135 		<ul style="list-style-type: none"> The provider may call: 1-877-880-7007 <li style="text-align: center; padding: 5px 0;">OR The completed form may be faxed to 1-617-562-5296

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/f-downloadable_forms.html Approval is good for one year.

Step 1 Please complete patient and physician information (Please Print)

Patient Name: _____	Physician Name: _____
Address: _____	Address: _____
Sponsor ID: _____	Phone #: _____
Date of Birth: _____	Secure Fax: _____

Step 2 Please indicate the specific product for which prior authorization is requested: _____

- 2** DoD preferred (formulary) growth hormone products include: Norditropin, Norditropin Nordiflex; Nutropin, Nutropin AQ; Serostim, Tev-Tropin; and Zorbtive.
 Non-formulary growth hormone products: Genotropin, Humatrope, Omnitrope, and Saizen

Step 3 Please complete the clinical assessment:

1. Is the patient a child (<18 years old)?	<input type="checkbox"/> Yes Please proceed to question 5	<input type="checkbox"/> No Please proceed to question 2
2. Is the patient an adult with lowered growth hormone levels secondary to the normal ageing process, obesity or depression?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to question 3
3. Is the patient an adult with growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy, acquired as an adult or diagnosed during childhood?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Please proceed to question 4
4. Does the patient have Short Bowel Syndrome or Acquired Immunodeficiency Syndrome (AIDS) wasting or cachexia?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Coverage not approved
5. Is the patient a child with non-growth hormone deficient short stature (Idiopathic Short Stature)?	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> No Please proceed to question 6
6. Is the patient a child with one of the following conditions? <input type="checkbox"/> Growth Hormone Deficiency <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Turner's Syndrome <input type="checkbox"/> Short stature homeobox gene <input type="checkbox"/> Noonan Syndrome (SHOX) deficiency <input type="checkbox"/> Chronic renal insufficiency <input type="checkbox"/> Small for gestational age (or other known renal indications)	<input type="checkbox"/> Yes Please proceed to question 7	<input type="checkbox"/> No Coverage not approved
7. Has the patient been evaluated by a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	<input type="checkbox"/> Yes Please sign and date below	<input type="checkbox"/> No Coverage not approved

Step 4 I certify the above is correct and accurate to the best of my knowledge.

4 Please sign and date

 Prescriber Signature

 Date