BlueCross BlueShield Federal Employee Program

ADULT GROWTH HORMONE PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

For Standard Option patients Norditropin is a preferred product. Please consider prescribing the preferred product.
Standard Option patients who switch to the preferred product can receive up to 2 fills without a copay for the benefit year.

Adult Growth Hormone

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Genotropin	**❑Norditropin**	**❑Saizen**	**❑Zomacton**
❑Humatrope	**❑Omnitrope**	**❑Sogroya**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Is this **INITIATION** of therapy for the patient? ***Please select answer below:***
   ❑ **NO –** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 3**
   ❑ **YES –** this is **INITIATION** of therapy, please answer the questions below:
2. **Non-Preferred Product Request (Standard Option Patient)**: Would you like to participate in this program and switch the patient to Norditropin? ❑Yes ❑No* ***(*If NO, please answer the following questions)***
   a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Norditropin? ❑Yes ❑No*
      ***If NO**, is there a clinical reason for not trying Norditropin? ❑Yes* ❑No
         ***If YES**, please specify: _____
   b. Does the patient require a reduction of treatment burden with fewer injections? ❑Yes ❑No
3. Does the patient have radiographic evidence within the last 12 months of open epiphyses? ❑Yes ❑No
4. Does the patient have evidence of tumor activity or active neoplasm? ❑Yes ❑No
5. Is this medication being used for cosmetic, anti-aging, or athletic performance enhancement? ❑Yes ❑No
6. Will this medication be used in combination with another somatropin agent such as Serostim, Zorbtive, or any other growth hormone? ❑Yes* ❑No
   ***If YES**, please specify the medication: _____
7. Will this medication be used in combination with Voxzogo (vosoritide)? ❑Yes ❑No
8. **Norditropin Request (Standard Option):** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Genotropin, Humatrope, Ngenla, Omnitrope, Saizen, Skytrofa, Sogroya, or Zomacton (formerly Tev-Tropin)? ❑Yes* ❑No
   ***If YES**, please select medication below:
   ❑Genotropin ❑Humatrope ❑Ngenla ❑Omnitrope ❑Saizen ❑Skytrofa ❑Sogroya ❑Zomacton
9. What is the patient's diagnosis?
   ❑Burn wounds (used for promotion of wound healing in burn patients) ❑Prader-Willi Syndrome ❑Noonan Syndrome
   ❑SHOX (short stature homeobox-containing gene deficiency) ❑Turner Syndrome

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Child was born small for gestational age

a. Has the patient failed to manifest catch-up growth by age 2 to 4? ❑Yes ❑No

❑Chronic renal insufficiency

a. Has the patient had a renal (kidney) transplant? ❑Yes ❑No

❑Growth hormone deficiency (inadequate secretion of endogenous growth hormone)

a. What is the cause of the patient's growth hormone deficiency? ***Please select the cause below:***

❑ Hypothalamic disease ❑ Idiopathic childhood-onset ❑ Radiation therapy ❑ Trauma
❑ Idiopathic adult-onset ❑ Pituitary disease ❑ Surgery
❑ Other cause ***(please specify)***: _____

b. Does the patient have a documented result from one of the following growth hormone stimulation tests: insulin tolerance test, glucagon, arginine/L-dopa, or arginine? ❑Yes***** ***(*If YES, select test below and provide result)*** ❑No

❑ Arginine test result: _____ ng/ml ❑ Glucagon test result: _____ng/ml
❑ Arginine/L-Dopa test result: _____ ng/ml ❑ Insulin tolerance test result: _____ng/ml

❑Other test ***(specify test and result)***: _____

c. Does the patient have panhypopituitarism which is defined as having a deficiency of 3 or more pituitary hormones such as Gonadotropin (LH and/or FSH), Adrenocorticotropic hormone (ACTH), Thyroid-stimulating hormone (TSH), and Arginine vasopressin (AVP)? ❑Yes***** ❑No

****If YES***, does the patient have documentation of an IGF-1 level below the age and sex appropriate reference range? ❑Yes ❑No

d. Is the growth hormone stim test level less than 10? ❑Yes ❑No***** ❑This test has not been done*****

****If NO OR Test Has Not Been Done***, please answer the following questions:

i. Is the IGF-1 level subnormal for the patient's age? ❑Yes ❑No ❑This test has not been done

ii. Is the IGFBP-3 level subnormal for the patient's age? ❑Yes ❑No ❑This test has not been done

e. Is the patient's height below the 3rd percentile for age? ❑Yes ❑No*****

****If NO***, is the growth hormone deficiency due to CNS lesions? ❑Yes ❑No

❑Idiopathic short stature (ISS) aka non-growth hormone-deficient short stature

a. Is the patient's height standard deviation score (SDS) less than or equal to -2.25? ❑Yes ❑No

b. Has it been determined that the growth rate will not permit attainment of adult height in normal range? ❑Yes ❑No

c. Did the diagnostic evaluation exclude other causes associated with short stature that should be observed or treated by other means? ❑Yes ❑No

❑Panhypopituitarism

a. Does the patient have documentation of an IGF-1 level below the age and sex appropriate reference range? ❑Yes ❑No

❑Other ***(please specify)***: _____

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Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

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CONTINUATION OF THERAPY (PA RENEWAL)
Adult Growth Hormone

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑Genotropin	**❑Norditropin**	**❑Saizen**	**❑Zomacton**
❑Humatrope	**❑Omnitrope**	**❑Sogroya**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Is this **INITIATION** of therapy for the patient? ***Please select answer below:***
   - ❑ **YES** – this is **INITIATION** of therapy, please answer the questions on **PAGE 1**
   - ❑ **NO –** this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. **Non-Preferred Product Request (Standard Option Patient)**: Would you like to participate in this program and switch the patient to Norditropin? ❑Yes ❑No* ***(*If NO, please answer the following questions)***
   a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to Norditropin? ❑Yes ❑No*
   ***If NO**, is there a clinical reason for not trying Norditropin? ❑Yes* ❑No
   ***If YES**, please specify: _____
   b. Does the patient require a reduction of treatment burden with fewer injections? ❑Yes ❑No
3. What is the patient's diagnosis?

❑Noonan Syndrome
❑Prader-Willi Syndrome
❑Turner Syndrome
❑Burn wounds (used for promotion of wound healing in burn patients)
❑Idiopathic short stature (ISS) aka non-growth hormone-deficient short stature
❑SHOX (short stature homeobox-containing gene deficiency)
❑Child was born small for gestational age
   a. Has the patient failed to manifest catch-up growth by age 2 to 4? ❑Yes ❑No
❑Chronic renal insufficiency
   a. Has the patient had a renal (kidney) transplant? ❑Yes ❑No
❑Growth hormone deficiency (inadequate secretion of endogenous growth hormone)
   a. What is the cause of the patient's growth hormone deficiency? ***Please select the cause below:***
      ❑Hypothalamic disease ❑Idiopathic childhood-onset ❑Pituitary disease ❑Surgery
      ❑Idiopathic adult-onset ❑Panhypopituitarism ❑Radiation therapy ❑Trauma
      ❑Other cause ***(please specify)***: _____

❑Other ***(please specify)*:** _____

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL QUESTIONS

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PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

4. Does the patient have radiographic evidence within the last 12 months of open epiphyses? ❑Yes ❑No
5. Does the patient have evidence of tumor activity or active neoplasm? ❑Yes ❑No
6. Does the patient have a growth velocity of more than 2cm per year? ❑Yes ❑No
7. Is the patient experiencing any significant side effects? ❑Yes ❑No
8. Has the patient been compliant with therapy? ❑Yes ❑No
9. Is this medication being used for cosmetic, anti-aging, or athletic performance enhancement? ❑Yes ❑No
10. Will this medication be used in combination with another somatropin agent such as Serostim, Zorbtive, or any other growth hormone? ❑Yes* ❑No
    If YES, please specify the medication: _____
11. Will this medication being used in combination with Voxzogo (vosoritide)? ❑Yes ❑No