BlueCross BlueShield Federal Employee Program®

# GROWTH HORMONE PEDIATRIC 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 and Basic Option patients Norditropin is a preferred product. Please consider prescribing the preferred product. Patients who switch to the preferred product can receive up to 2 fills without a copay for the benefit year.**

## Skytrofa (pediatric)

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

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

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

1. **Standard/Basic 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
2. Does the patient have a diagnosis of growth hormone deficiency (inadequate secretion of endogenous growth hormone)? ❑Yes ❑No
3. What is the patient's weight? _____ kg **OR** _____ lbs
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. 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. Is this **INITIATION** of therapy for the patient? ***Please select answer below:***

❑ **YES –** this is **INITIATION** of therapy, please answer the following questions:
   a. Is the growth hormone stim test level less than 10? ❑Yes ❑No* ❑This test has not been done*
   ***If NO or This 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
   b. 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

❑ **NO –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:
   a. Does the patient have a growth velocity of more than 2cm per year? ❑Yes ❑No
   b. Is the patient experiencing any significant side effects? ❑Yes ❑No
   c. Has the patient been compliant with therapy? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.