BlueCross BlueShield Federal Employee Program

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 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

****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. 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. **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

3. Does the patient have radiographic evidence within the last 12 months of open epiphyses? ❑Yes* ❑No
   ***If YES**, what is the patient's weight? _____ kg **OR** _____ lbs

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. What is the patient's diagnosis?
   ❑Burn wounds (used for promotion of wound healing in burn patients)
   ❑Panhypopituitarism
   a. Does the patient have documentation of an IGF-1 level below the age and sex appropriate reference range? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 – PHYSICIAN COMPLETES

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

❑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

❑Other ***(please specify)***: _____

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Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

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   ***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?
   ❑Burn wounds (used for promotion of wound healing in burn patients)
   ❑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)*:** _____
4. Does the patient have radiographic evidence within the last 12 months of open epiphyses? ❑Yes* ❑No
   ***If YES**, what is the patient's weight? _____ kg **OR** _____ lbs
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