Continuation Growth Hormone Prior Authorization Form

Physicians Plus

START HERE

Member & Prescriber Information

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

Criteria

Endocrinologist or nephrologist must be involved in request/care.

An approved *Initiation PA form* must already be on file prior to the review of the continuation request.

Provide legible copies of growth chart showing improvement and radiological reports.

Drug company supported programs do not replace this PA requirement.

Approval duration is 12 months — reauthorization required.

Diagnosis: ☐ GH deficiency ☐ Turner's Syndrome ☐ HIV with cachexia
☐ Prader-Willi Syndrome ☐ Other: _____

Children: All information must be provided
(Radiographic report may be requested if not already submitted)

Baseline growth rate (cm/yr): _____

First post-treatment period growth rate (cm/yr)[1]: _____

Subsequent post-treatment period growth rates - list all annual rates (cm/yr)[2]: _____

_____

☐ Radiological evidence that the epiphyses have not yet closed (children > 10 years old)

[1] After the first post-treatment period, a doubling of growth rate required or a growth rate increase by >3 cm/yr.
[2] Growth rate must remain > 2.5 cm/yr.

Turner's Syndrome (all the criteria must be met)

☐ Bone age < 14 years old
☐ Growth velocity > 2.5 cm/yr. during most recent assessment period
☐ Current height not consistent or approximate with final expected height

Adults: Supply medical record documentation to support use

Choose Product

☐ **Norditropin Flexpro:** ☐ 5mg/1.5ml ☐ 10mg/1.5ml ☐ 15mg/1.5ml
☐ **Norditropin Nordiflex:** ☐ 30mg/3ml
☐ Serostim: ☐ 4mg ☐ 5mg ☐ 6mg
☐ Other (specify name, form & strength): _____

Sign/Date & Mail or Fax

Prescriber Signature: _____ **Date:** _____

Prescriber NPI: _____

Mailing Address
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