

Date of Request _____

Norditropin – somatropin

Thank you for selecting a Preferred Agent

Member Information

Name _____
 Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth Date _____
 Address _____
 City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
 Gender (Circle)
 Male Female
 AGE: _____

Practitioner Information

Name _____
 Agent / Contact Name _____ Specialty _____
 Office / Clinic Name _____
 Address _____
 City State Zip _____
 Phone () - Fax () -
 Email _____ @ _____

Primary Diagnosis Condition / Diagnosis Related – Reason for Request

- Diagnosis:
 - Pediatric Growth Hormone Deficiency
 - Turner Syndrome
 - Small for Gestational Age (SGA)
 - Noonan Syndrome
 - Adult Growth Hormone Deficiency
- Number of standard deviations the height is below the mean height for a normal child of the same age and gender? _____
- Insulin-like Growth Factor-1 (IGF-1) concentration? _____ H / L
- IGF Binding Protein-3 (IGFBP-3) concentration? _____ H / L
- Provocative Stimulation Test level? _____ H / L
 - Indicate test _____

Strength / Dose

Duration of Therapy (Expected)

Formulary Alternatives Attempted/Outcome

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? Y N
 Pharmacy Phone Number

Practitioner Signature

Date Received: _____
 Reviewed By: _____
 Forwarded To: _____

**FAX Form to
 877-800-5633**