

Date of Request \_\_\_\_\_

## Nutropin – somatropin

This Product is a Non-Preferred Agent. Preferred Agents are **Genotropin, Humatrope, Norditropin**. Use of a Non-Preferred Agent may result in additional utilization controls as well as increased patient co-pays. Please consider prescribing 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 (GHD)
  - Growth failure due to Chronic Renal Insufficiency (CRI)
  - Idiopathic Short Stature (ISS)       Turner 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**

HealthTrans Prior Authorization  
 866-805-1690

Date of Request \_\_\_\_\_

## Genotropin – 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     Small for Gestational Age (SGA)
  - Prader-Willi Syndrome (PWS)             Turner Syndrome
  - Idiopathic Short Stature (ISS)
  - 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**

Date of Request \_\_\_\_\_

## Humatrope – 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
  - Small for Gestational Age (SGA)       SHOX Deficiency
  - Turner Syndrome       Idiopathic Short Stature (ISS)
  - 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: \_\_\_\_\_

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HealthTrans Prior Authorization  
 866-805-1690

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**

HealthTrans Prior Authorization  
 866-805-1690