

Protropin

Protropin (Somatrem) is Human Growth Hormone.

Patient diagnosed with one of the following conditions with corresponding criteria:

Pediatric Growth Hormone Deficiency (GHD)-diagnosis confirmed by at least one subnormal provocative stimulation test; height at ≥ 2.5 standard deviation below the mean height for normal children of same age and gender; epiphyses still open confirmed by radiograph of wrist and hand. [6 months] Reevaluate for height increase. [6 months]

Growth failure due to Chronic Renal Insufficiency (CRI)- height at ≥ 2.5 standard deviation below the mean height for normal children of same age and gender; patient not had successful renal transplantation. [6 months]

Growth failure due to small for gestational age- height at ≥ 2.5 standard deviation below the mean height for normal children of same age and gender; patient's birth weight less than 2.5 kg at gestational age > 37 weeks; patient's birth length or weight below the 3rd percentile for gestational age. [6 months]

Short stature associated with Turner Syndrome- height at ≥ 2.5 standard deviation below the mean height for normal children of same age and gender. [6 months]

Prader-Willi Syndrome- height at ≥ 2.5 standard deviation below the mean height for normal children of same age and gender. [6 months]

Idiopathic short stature- height ≥ 2.5 standard deviation below the mean height for normal children of same age and gender; epiphyses still open confirmed by radiograph of hand and wrist. [6 months] Reevaluate for height increase. [6 months]

Adult Growth Hormone Deficiency- hypopituitarism due to pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma; other hormonal deficiency, if applicable, being treated; diagnosis confirmed by at least one subnormal provocative stimulation test. [6 months] Reevaluate for clinical benefit shown by one of the following: insulin-like growth factor I (IGF-I) in normal range for age and sex; improvement in blood lipid levels; improvement in waist to hip ratio; improvement in body composition; improvement in quality of life; reduction in cardiovascular risk factors. [6 months]



Prior Authorization Request

Date of Request _____

Enrollment / Cardholder ID _____
 Group / Plan _____
 Birth date _____
 Address: _____
 City State Zip _____

Gender (Circle)
 Male Female
 AGE: _____ Weight (kg): _____

Practitioner Information

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

Height
Baseline _____
Current _____

Requested Drug / Pharmaceutical

Protropin (Somatrem)

Strength / Dose

Therapy Start Date

Condition / Diagnosis Related - Reason for Request

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Duration of Therapy (Expected)

Type of Request (Circle)
One-Time On-Going

Clinical Drug / Lab History Pertinent to Request

<u>Labs:</u>	<u>Baseline / Ongoing</u>
Formulary Alternative(s) Attempted YES NO (Circle) Please List:	

Contact Pharmacy? Y N
Pharmacy Phone Number

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Practitioner Signature