HEALTHTRANS

Prior Authorization Request

Date of Request ____________________

Saizen – 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
  - ☐ 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

HEALTHTRANS

Prior Authorization Request

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

HealthTrans Prior Authorization
866-805-1690

HEALTHTRANS

Prior Authorization Request

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: ____________________

FAX Form to 877-800-5633

HealthTrans Prior Authorization

866-805-1690

HEALTHTRANS

Prior Authorization Request

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