

The following documentation is REQUIRED for prior authorization. Please attach supporting documentation for all information included below. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at www.bcbsks.com

Today's Date: _____

PATIENT INFORMATION

Patient Name: _____ Address: _____ City/State/Zip: _____
 Phone Number: _____ Date of Birth: _____

INSURANCE INFORMATION (please include copy of front and back of insurance card if possible)

Primary Insurance _____	Secondary Insurance _____
Subscriber _____ DOB _____	Subscriber _____ DOB _____
Policy/Employer/Group # _____	Policy/Employer/Group # _____
Insurance Company Phone _____	Insurance Company Phone _____
Subscriber ID # _____	Subscriber ID # _____

Patient's diagnosis:

- Growth Hormone Deficiency GH insufficiency or partial GH deficiency Noonan Syndrome
 Prader-Willi Syndrome Turner Syndrome Panhypopituitarism
 Renal dialysis with growth failure Acquired adult GHD secondary to structural lesions or trauma
 ESRD with glomerular filtration rate less than 75ml/min/1.73 m² Other: _____

Growth Hormone Stim Tests are required for ALL PATIENTS: (1 for adults, 2 for children.) **Attach copy of Stim Test results**

Agent 1: Peak: _____

 Agent 2: Peak: _____

Additional Lab Tests: (i.e. IGF-1, TSH, FSH/LH, ACTC) **Attach copy of lab results**

Test: _____	Result: _____	Date: _____
Test: _____	Result: _____	Date: _____
Test: _____	Result: _____	Date: _____
Test: _____	Result: _____	Date: _____

Information Required for ALL PATIENTS:

- Please list all reasons for selecting the requested **medication** over alternative GH products (e.g. adverse reaction to other GH products.) _____
- How often will the patient be seen for follow-up? _____ Date last seen: _____
- Date GH treatment started: _____

Information Required for CHILDREN: (Please provide relevant chart information i.e. growth curves, imaging studies)

- Does the patient have open epiphyses? Yes No
- Does the patient have complicating factors (including malnutrition and acidosis?) Yes No
 If Yes, have the complicating factors been treated? Yes No
- Bone Age: _____ Date Measured _____ Patient's age when bone age Measured: _____
 Height (cm) at diagnosis: _____ Percentile of normal height _____
 Mid-Parental Height: _____ Growth Rate (cm/year) at diagnosis _____
 Current Growth Rate (For Renewals only): _____

Information Required for ADULTS: (i.e. Stim tests, growth charts)

- Does the patient's medical history include childhood onset of growth hormone deficiency that was confirmed by testing during childhood? Yes No
 - Has imaging demonstrated hypothalamic disease or injury or pituitary disease or injury? Yes No
- Renewal:**
- Has growth hormone therapy resulted in demonstrated clinical improvement since initiation of therapy? Yes No
 If Yes, has improvement continued for or been maintained for one year or longer? Yes No

Rx Order Form

OMNITROPE®

- 5.8 mg (5 mg/mL)
 Pen 5 (Dose in increments of 0.05 mg)
 Pen 10 (Dose in increments of 0.1 mg)
 Other Growth Hormone _____

(**Note: approval requires trial and failure of Omnitrope®)

Form: _____
Strength/Dose: _____

Quantity: _____

Directions/ Frequency: _____

Refills: _____

Ancillary supplies as needed per injection (i.e., needles, syringes, alcohol wipes)

Does the patient need training? **Yes** **No**

Prescriber Name: _____

Physician NPI#: _____ **Signature:** _____

Specialty: _____ **Contact Name:** _____

Clinic Name: _____

Clinic Address: _____

City, State, Zip: _____

Phone #: _____ **Fax #:** _____

Pharmacy: **Triessent (888-216-6710)** **Other** _____

Please fax or mail this form to:

Prime Therapeutics LLC
 Clinical Review Department
 1305 Corporate Center Drive
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130
Phone: 866.469.5660

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