Growth Hormone Prior Authorization Request

Physician Fax Form

NOTE: Only the prescriber may complete this form.

Section 1 – Patient Information

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 website at **www.bcbsks.com**. Please include a copy of the front and back of the insurance card, if possible.

_____ /_____ /________
Today's Date

First Name ______ MI ______

Last Name ______ Suffix ______

Street Address ______

City ______

State ______ ZIP Code ______ +4 ______

(_____) _____-________
Phone Number

_____ /_____ /________
Date of Birth

Primary Insurance Carrier ______

Subscriber Name ______

Policy Number ______

Employer/Group Number ______

Subscriber ID Number ______

(_____) _____-________
Insurer Phone Number

Secondary Insurance Carrier ______

Subscriber Name ______

Policy Number ______

Employer/Group Number ______

Subscriber ID Number ______

(_____) _____-________
Insurer Phone Number

Section 2 – Patient Diagnosis Information

- ☐ Growth Hormone Deficiency
- ☐ GH Insufficiency or Partial GH Deficiency
- ☐ Noonan Syndrome
- ☐ Prader-Willi Syndrome
- ☐ Turner Syndrome
- ☐ Panhypopituitarism
- ☐ Renal Dialysis with Growth Failure
- ☐ Acquire Adult GHD Secondary to Structural Lesions or Trauma
- ☐ ESRD with Glomerular Filtration Rate Less than 75ml/min/1.73m^2
- ☐ Other ______

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

Test ______

Result ______ Date of Test _____ /_____ /________

Test ______

Result ______ Date of Test _____ /_____ /________

Test ______

Result ______ Date of Test _____ /_____ /________

Test ______

Result ______ Date of Test _____ /_____ /________

Growth Hormone Stim Tests are required for **all patients** (one for adults, two for children). Attach copy of Stim Test results.

Agent 1 ______ Peak ______

Agent 2 ______ Peak ______

Confidentiality Notice

This fax is for the sole use of the intended recipient(s) and may contain proprietary, confidential, trade secret or privileged information. Any unauthorized review, use, disclosure or distribution is prohibited and may be a violation of law. If you are not the intended recipient, please contact the sender and destroy all copies of the original fax.

Please continue on the next page.

Section 3 – Required Information 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

When was treatment started?

_____ /_____ /_______
Date GH Treatement Started

Section 4 – Required Information 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 of Birth: _____ /_____ /_______

Patient's Age When Measured: ______________

Height (cm) at Diagnosis: ______________

Percentile of Normal Height: ______________

Mid-Parental Height: ______________

Growth Rate (cm/yr) at Diagnosis: ______________

Current Growth Rate (renewals only): ______________

Section 5 – Required Information for Adults

Please provide relevant chart information (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

Section 6 – Rx Order Form

☐ BCBSKS Preferred Product
☐ Other Growth Hormone:

____
NOTE: Approval requires trial and failure of the preferred agent

Form: ______________ Strength/Dose: ______________

Quantity: ______________ Refills: ______________

Directions/Frequency: ______________________________

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

Does the patient need training? ☐ Yes ☐ No

Pharmacy: ☐ Accredo
Phone: 833-721-1620
Fax: 888-302-1028

☐ Other ______________

Prescriber Name: ______________________________

Specialty: ______________ Physician NPI Number: ______________

Signature: ______________________________

Contact Name: ______________________________

Clinic Name: ______________________________

Street Address: ______________________________

City: ______________ State: _____ ZIP Code: _______

Phone Number: (_____) _____-_______

Fax Number: (_____) _____-_______

Please email, fax or mail this completed form to:
Blue Cross and Blue Shield of Kansas
Attn: Prior Authorization
1133 SW Topeka Blvd, Topeka, KS 66629-0001
Fax: 785-290-0711 Email: csc@bcbsks.com