Growth Hormone Prior Authorization Request

BlueCross BlueShield Kansas

Physician Fax Form

NOTE: Only the prescriber may complete this form.

Section 1 – Patient Information

CLEAR DATA

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

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

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

☐ Norditropin Flexpro®
- ☐ 5 mg/1.5 mL
- ☐ 10 mg/1.5 mL
- ☐ 15 mg/1.5 mL
- ☐ 30 mg/3 mL

☐ 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 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