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 – Rx Order Form

☐ BCBSKS Preferred Product
☐ Other Growth Hormone: _____

NOTE: Approval requires trial and failure of the preferred agent

Is this a renewal? ☐ Yes ☐ No

_____ /_____ /_____
If Yes, Give Date Started

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 continue on the next page.

Section 3 – Patient Diagnosis Information

Please write diagnosis, requiring diagnosis coding and description of diagnosis.

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 _____

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 – Confidentiality Notice

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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