GROWTH HORMONE DEFICIENCY DISORDER

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: ❍ M ❍ F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ICD-10:_____ ICD-10 Description: _____Others:_____ Description: _____

Weight: _____ ❑ lb ❑ kg

Prior Tried and Failed Therapies:

1 _____
2 _____
3 _____
4 _____
5 _____

Height: _____ ❑ in ❑ cm

Indicate length of therapy: _____

Contraindication to growth hormone therapy:
❑ Active malignancy
❑ Acute critical illness
❑ Active proliferative diabetic retinopathy

For female patients: Is the patient currently on estrogen containing oral contraceptive? ❑ Yes ❑ No ❑ N/A

Serum Insulin-like Growth Factors-1 (IGF-1): _____ ng/mL

Insulin-like Growth Factor Binding Protein 3 (IGFBP-3): _____ ng/mL

Does patient have dyslipidemia? ❑ Yes ❑ No

Does patient have diagnosis of osteopenia or osteoporosis? ❑ Yes ❑ No

Does patient have diagnosis of diabetes mellitus? ❑ Yes ❑ No

Genetic syndromes:
❑ Turner syndrome ❑ Prader-Willi syndrome ❑ Noonan syndrome
❑ Down syndrome ❑ Bloom syndrome

Was patient previously diagnosed with structural hypothalamic/pituitary disease or have evidence of other pituitary hormone deficiency? ❑ Yes ❑ No

If yes, have the patient undergone hypothalamic/pituitary surgery or irradiation? ❑ Yes ❑ No

PROVOCATIVE TESTS:

❑ Insulin Intolerance Test (ITT) Date:_____
❑ Growth Hormone-Releasing Hormone (GHRH) Argininge Test Date:_____
❑ Glucagon Stimulation Test Date:_____

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: ❍ Pharmacist to Provide Training ❍ Patient Trained in MD Office ❍ Manufacturer Nurse Support

5 PRODUCT DELIVERY: ❍ Patient's Home ❍ Physician's Office ❍ Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
❑ GENOTROPIN® (SOMATROPIN)	Genotropin Lyophilized Powder in Cartridge: ❑ 5 mg ❑ 12mg Genotropin MINIQUICK Cartridge (Preservative Free): ❑ 0.2 mg ❑ 0.4 mg ❑ 0.6 mg ❑ 0.8 mg ❑ 1.0 mg ❑ 1.2 mg ❑ 1.4 mg ❑ 1.6 mg ❑ 1.8 mg ❑ 2 mg	❑ _____		
❑ HUMATROPE® (SOMATROPIN)	❑ 5 mg vial with 5-mL diluent vial Cartridge with Prefilled Syringe of Diluent: ❑ 6 mg ❑ 12 mg ❑ 24 mg	❑ _____		
❑ SAIZEN® (SOMATROPIN)	Saizen: ❑ 5.5 mg vial ❑ 8.8 mg vial Saizen Click.Easy: ❑ 4 mg vial ❑ 8.8 mg vial Saizenprep: ❑ 8.8 mg	❑ _____		
❑ SOGROYA (SOMAPACITAN-BECO)	❑ 10 mg/1.5 mL single-patient use prefilled pen	❑ _____		
❑ ZOMACTON® (SOMATROPIN)	❑ 5 mg vial ❑10 mg vial ❑10 mg vial (for Zoma-Jet)	❑ _____		
❑ _____	_____	_____		

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted **Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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