P.O. Box 30192
Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3219
Fax 801-442-3006

selecthealth

PREAUTHORIZATION FORM

Genotropin™, Humatrope™, Norditropin™, Nutropin™, Nutropin AQ™, Protropin™, Omnitrope™, Zorbtive™, and Serostim™ Non-Preferred Growth Hormone Agents

Therapeutic use: Treatment of physiologic and anatomical abnormalities associated with growth hormone deficiency

Quantity Limits: NA

Authorization Period: 12 months

Distribution Information: Intermountain HomeCare is the preferred distributor of growth hormone. Saizen and Tev-Tropin are the preferred growth hormone agents.

Patient's name _____

Patient's ID# ☐☐☐ ☐☐ ☐☐☐☐ DOB ☐☐/☐☐/☐☐☐☐

ICD-9 ☐☐☐ ☐☐ ☐☐☐ ☐☐ _____

Physician's name_____

Physician's Ph# (☐☐☐ ☐☐☐- ☐☐☐☐ Fax# ☐☐☐- ☐☐☐☐

Physician's signature_____ Date signed ☐☐/☐☐/☐☐☐☐

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

	Please check "Yes" or "No" or answer the following questions:		
1.	Which brand of growth hormone is being requested? _____		
2.	Is the patient diagnosed with any of the following? (Please check below). ❑ AIDs-related wasting ❑ Chronic renal insufficiency and has not yet received renal transplantation ❑ Prader-Willi Syndrome ❑ Pediatric GHD ❑ Adult GHD ❑ Turner Syndrome	❑ Yes	❑ No
3.	Does the patient have a diagnosis of pituitary disease or is diagnosed with acquired growth hormone deficiency? Please list secondary cause:_____	❑ Yes	❑ No
4.	Please complete the following data if applicable. Height (cm):_____ Date:_____ Annualized growth rate (cm/yr):_____ GH stimulation test (peak):_____ Date:_____ IGF-1 (please include normal range):_____ Date:_____ IGFBP-3 (please include normal range):_____ Date:_____ Bone age:_____ Date:_____		
5.	Is the patient diagnosed with small for gestational age and not caught up in height by age 2? Birth weight:_____ Gestational age:_____	❑ Yes	❑ No
6.	Have chart notes and laboratory results been included, which document the patient's workup for GH necessity AND reasons why the patient cannot use a preferred product (Tev-Tropin or Saizen)?	❑ Yes	❑ No

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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