SANDHILLS CENTER

Pharmacy Request for Prior Approval – Growth Hormone (Adult 21 Years of Age and Older)

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Recipient Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

1. Diagnosis: _____

For NON-PREFERRED DRUGS (*complete this section as well as below*):

2. ___ Failed two preferred drugs. List preferred drugs failed: _____

Or list reason why patient cannot try two preferred drugs: _____

3. History of:
☐ Turners Syndrome ☐ Prader Willi Syndrome
☐ Craniopharyngioma ☐ Panhypopituitarism ☐ Cranial Irradiation
☐ MRI History of Hypopituitarism list: _____ ☐ Hypopituitarism
☐ Chronic Renal Insufficiency ☐ SGA with IUGR ☐ Other: _____

4. Was the patient diagnosed as a child? Yes___ No___
5. Did the patient have a height velocity < 25th Percentile for Bone Age? Yes___ No___ **Height Velocity:** _____
6. Did the patient have low serum levels of IGF-1 and IGFBP-3? Yes___ No___ **IGF-1 Level:** _____ **IGFBP-3 Level:** _____
7. Did the patient have other signs of hypopituitarism? Yes___ No___ List: _____
8. Was the patient an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia? Yes___ No___
9. Was the patient's height < 3rd percentile for chronological age? Yes___ No___ **Height:** _____ **Percentile:** _____
10. Was birth weight and/or length more than 2 standard deviations below mean for gestational age with no catch up by age 2? Yes___ No___
11. Is the patient currently being treated and diagnosed with GHD in childhood with a current low IGF-1? Yes___ No___
IGF-1 Level: _____
12. Is the patient currently being treated and diagnosed with short stature in childhood with height > 2.25 standard deviations below mean for age, and bone age > 2 standard deviations below mean, and low serum levels of IGF-1 and IGF-BP3?
Yes___ No___ **IGF-1 Level:** _____ **IFG-BP3 Level:** _____
13. Is GHD documented by a negative response to a GH stimulation test? Yes___ No___
Agent 1: _____ **Agent 2:** _____ **Peak:** _____ **Ng/ml:** _____
14. Document cause of GHD (pituitary/hypothalamic disease, radiation, surgery, trauma): _____

Zorbitive only:

15. Is there a history of short bowel syndrome in the last 2 years? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax to: 1-833-727-3741 or Call PerformRx for help: 1-888-846-1062