BlueCross BlueShield Nebraska

GROWTH HORMONE PREAUTHORIZATION POLICY X.6 PHYSICIAN FAX FORM

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization electronically.* Visit MedicalPolicy.NebraskaBlue.com to begin using this free service.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient Information

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:

Insurance Information

BCBSNE ID Number:	Group Number:

Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, ZIP:		Phone Number:		Secure Fax Number:

Preauthorization Information

This request is for a(n)..... ☐ Child ☐ Adult
Growth hormone requested: _____ Daily dose requested: _____ Patient weight: _____
Patient's diagnosis to be treated with requested medication (ICD 10 code): _____
If requested product is not Norditropin®, has the patient tried and failed Norditropin®?..... ☐ Yes ☐ No
If no, please list any contraindications, drug allergies, or adverse effects to treatment with Norditropin®: _____
_____
Is this a preauthorization request for renewal of growth hormone?..... ☐ Yes ☐ No
If yes, when was the growth hormone therapy started? _____ (Please proceed to renewal section)

Children: INITIAL Request Section

Patient height (cm or inches): _____ Height SD below the mean: _____ Patient is at the _____ percentile for age
Growth velocity (cm/year): _____ Bone age: _____
Results of TWO GH stimulation tests (list test and results): _____
_____

1. If diagnosis of chronic renal insufficiency, is the patient post-transplant?..... ☐ Yes ☐ No
   Creatinine clearance (mL/min): _____
2. Is the deficiency the result of congenital, genetic, or acquired causes (i.e., pituitary disease or tumor, hypothalamic disease, surgical damage, etc)?..... ☐ **Yes** ☐ **No**
3. If diagnosis is AID/HIV wasting syndrome or cachexia, is the patient receiving treatment with antiretroviral agents?
4. If diagnosis is short bowel syndrome, is the patient dependent on specialized nutritional support?.....

Children: RENEWAL Request Section

1. Has the diagnosis of GHD, AIDS/HIV wasting, chronic renal insufficiency, PWS, Turner's syndrome, SHOX, Noonan syndrome, SGA, or idiopathic short-stature been established in the past?.....
2. Growth velocity (cm/year): _____
3. Epiphyses are open as determined by X-ray?.....
4. If diagnosis is chronic renal insufficiency, is the patient dependent on specialized nutritional support?.....

Adult: INITIAL Request Section

Results of TWO GH stimulation tests and IGF-I/GFBP-3 studies (list test and results): _____

1. Is the deficiency the result of congenital, genetic, or acquired causes (i.e., pituitary disease or tumor, hypothalamic disease, surgical damage, etc)? ☐ Yes ☐ No
2. If diagnosis is AID/HIV wasting syndrome or cachexia, is the patient receiving treatment with antiretroviral agents? ☐ Yes ☐ No
3. If diagnosis is short bowel syndrome, is the patient dependent on specialized nutritional support? ☐ Yes ☐ No

Adult: RENEWAL Request Section

1. Has the diagnosis of GHD, AIDS/HIV wasting been established in the past? ☐ Yes ☐ No
2. Is the patient's IGF-I concentration in the normal range for age and sex? ☐ Yes ☐ No

Please attach any additional information that should be considered with this request

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374