

# GROWTH HORMONE PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.**

**Incomplete forms will be returned for additional information.** The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit <https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth>

## PATIENT AND INSURANCE INFORMATION

Today's Date: \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:		City, State, Zip:	Patient Telephone:
BCBSTX ID Number:		Group Number:	

## PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

## PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis- ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
<b>For all requests:</b>	
1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, when was treatment with the requested medication started?</b> _____	
2. What is the patient's weight? _____ (kg)	
3. Does the patient have a diagnosis of an active malignancy in the last 180 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. Does the patient have a history of chemotherapy/radiation (CPTs) in the last 180 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Does the patient have a diagnosis of active proliferative or severe non-proliferative diabetic retinopathy in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Is there documentation to support the requested diagnosis? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. Please list the medications the patient has <b>previously tried and failed for treatment of this diagnosis</b> (Please specify if brand name, generic, extended-release products, or over-the-counter products): _____ Date(s): _____ Date(s): _____ _____ Date(s): _____ Date(s): _____ _____ Date(s): _____ Date(s): _____	
8. Please list all reasons for selecting the <b>requested medication</b> over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____ _____	
9. Please list all other medications the patient is <b>currently taking</b> for treatment of this diagnosis. _____ _____ _____	
<b>For Serostim requests:</b>	
10. Does the patient have a diagnosis of HIV in the last 3 years? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. Does the patient have a diagnosis of cachexia in the last 365 days? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Please continue to the next page.</b>	

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
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**For all other Growth Hormone requests:**

- 12. Does the patient have a diagnosis of growth hormone deficiency (GHD) in the last 3 years? .....  Yes  No
- 13. Does the patient have a diagnosis of panhypopituitarism in the last 3 years? .....  Yes  No
- 14. Does the patient have a diagnosis of idiopathic short stature (ISS) in the last 3 years? .....  Yes  No
- 15. Does the patient have a diagnosis of SHOX deficiency, Turner syndrome, or Noonan syndrome in the last 3 years? .....  Yes  No
- 16. Does the patient have a diagnosis of Prader-Willi syndrome in the last 3 years? .....  Yes  No  
 If yes, does the patient have a diagnosis of obstructive sleep apnea in the last 365 days? .....  Yes  No  
 If yes, does the patient have a history of CPAP or BiPAP in the last 730 days? .....  Yes  No
- 17. Does the patient have a diagnosis of chronic kidney disease (CKD) in the last 3 years? .....  Yes  No
- 18. Does the patient have a history of a renal transplant (CPT) in the last 365 days? .....  Yes  No
- 19. Does the patient have a diagnosis of papilledema in the last 180 days? .....  Yes  No

**Prescriber or Authorized Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.*

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

**Please fax or mail this form to:**  
 Prime Therapeutics LLC, Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.243.6930      Phone: 855.457.0407**

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