US Family Health Plan

Prior Authorization Request Form for

Growth Hormone

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after one year.

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID# _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2

Please indicate the specific product for which prior authorization is requested: _____

The DoD step preferred (formulary) growth hormone product is Norditropin FlexPro.
Formulary but non-step preferred growth hormone products: Zomacton, and Omnitrope.
Non – formulary growth hormone products: Genotropin, Humatrope, Nutropin AQ NuSpin, Ngenla, Serostim, Zorbtive, and Saizen.

Step 3 **Please complete the clinical assessment**

1.	Which medication is being requested?	☐ Ngenla – Proceed to question **2** ☐ All other medications – Proceed to question **9**	
2.	The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.	☐ Acknowledged Proceed to question **3**	
3.	How old is the patient?	☐ Greater than or equal to 3 years of age and less than or equal to 17 years of age – Proceed to question 4 ☐ Other – **STOP** Coverage not approved	
4.	Is Ngenla being used for the indication of growth failure due to an inadequate secretion of endogenous growth hormone (GH) in pediatric patients?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5.	Is the prescription written by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved

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6. ·Does the patient have a contraindication to Norditropin?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Has the patient experienced an adverse reaction to Norditropin, Omnitrope, AND Zomacton not expected with Ngenla? Note, all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton. Note that patient preference for a particular device is insufficient grounds for approval of an NF agent.	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Does the patient require a less than daily dosing regimen due to needle intolerance or aversion?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
9. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **13**	☐ No Proceed to question **10**
10. Is the patient a child with one of the following conditions? o Growth Hormone Deficiency o Small for gestational age o Chronic renal insufficiency associated with growth failure o Prader-Willi Syndrome (in patients with a negative sleep study for obstructive sleep apnea) o Turner Syndrome o Noonan's Syndrome o Short stature homeobox gene (ShoX) gene mutation	☐ Yes Proceed to question **12**	☐ No Proceed to question **11**
11. For patients younger than 18 years of age who do not have one of the indications mentioned above, please provide the diagnosis.	_____ Please write-in the diagnosis Proceed to question **12**	
12. Is the prescription written by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
13. Is the patient an adult with growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy, acquired as an adult or diagnosed during childhood?	☐ Yes Proceed to question **15**	☐ No Proceed to question **14**

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	14. Does the patient have HIV/AIDS wasting/cachexia or Short Bowel Syndrome?	☐ Yes Proceed to question **15**	☐ No **STOP** Coverage not approved
	15. Is the prescription written by or in consultation with an appropriate specialist (endocrinologist, infectious disease specialist, general surgeon, or gastroenterologist)?	☐ Yes Proceed to question **16**	☐ No **STOP** Coverage not approved
	16. Which medication is being requested?	☐ Norditropin FlexPro - **Sign and date below** ☐ Genotropin, Humatrope, Nutropin AQ Nuspin, Ngenla, Saizen, Zorbtive, Serostim, Omnitrope or Zomacton – Proceed to **17**	
	17. Does the patient have a contraindication to Norditropin FlexPro?	☐ Yes **Sign and date below**	☐ No Proceed to question **18**
	18. Has the patient experienced an adverse reaction to Norditropin FlexPro that is not expected with the non-step preferred product (Genotropin, Humatrope, Nutropin AQ Nuspin, Ngenla, Saizen, Zorbtive, Omnitrope, Serostim, or Zomacton)?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Please note that use of a Growth Stimulating Agent is not approved for the following: idiopathic short stature, the normal ageing process, obesity, or depression, other off-label uses (for example, non-alcoholic fatty liver disease, cirrhosis, mild cognitive impairment, etc.) or concomitant use of multiple Growth Stimulating Agents.

Step 4 **I certify that the above is correct to the best of my knowledge** (Please sign and date):

Prescriber Signature _____ Date _____