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 does not expire for adult indications.
Prior authorization expires after one year for pediatric indications.

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 products are Norditropin FlexPro, **Genotropin, Omnitrope, Zomacton, Ngenla, and Sogroya.**
Non – formulary growth hormone products: Humatrope, Nutropin AQ NuSpin, Serostim, Saizen, Saizen Prep, and Skytrofa.

Step 3 **Please complete the clinical assessment**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **5**	☐ No Proceed to question **2**
2. 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 **4**	☐ No Proceed to question **3**

	3. 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 **4**	
	4. Is the prescription written by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
	5. 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 **7**	☐ No Proceed to question **6**
	6. Does the patient have HIV/AIDS wasting/cachexia or Short Bowel Syndrome?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
	7. Is the prescription written by or in consultation with an appropriate specialist (endocrinologist, infectious disease specialist, general surgeon, or gastroenterologist)?	☐ 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 _____