

**Pharmacy Prior Approval Request for 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. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
 7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
 11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days

**Clinical Information**

1. Diagnosis: \_\_\_\_\_

**FOR NON-PREFERRED DRUGS: COMPLETE THIS SECTION AS WELL AS BELOW**

Failed two preferred drug(s). List preferred drugs failed: \_\_\_\_\_  
 Or list reason why patient cannot try two preferred drugs: \_\_\_\_\_

2. History of:  Turners Syndrome  Prader Willi Syndrome  Craniopharyngioma  
 Panhypopituitarism  Cranial Irradiation  MRI History of Hypopituitarism list:  Hypopituitarism  
 Chronic Renal Insufficiency  SGA with IUGR  Other: \_\_\_\_\_

3. Was the patient diagnosed as a child?  Yes  No

4. Did the patient have a height velocity < 25th Percentile for Bone Age.  Yes  No Height Velocity: \_\_\_\_\_

5. Did the patient have low serum levels of IGF-1 and IGFBP-3?  Yes  No IGF-1 Level: IGFBP-3 Level: \_\_\_\_\_

6. Did the patient have other signs of hypopituitarism?  Yes  No List: \_\_\_\_\_

7. Was the patient an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia?  Yes  No

8. Was the patient's height < 3rd percentile for chronological age?  Yes  No Height: \_\_\_\_\_ Percentile: \_\_\_\_\_

9. 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

10. Is the patient currently being treated and diagnosed with GHD in childhood with a current low IGF-1?  Yes  No  
 IGF-1 Level: \_\_\_\_\_

11. 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: IGF-BP3 Level: \_\_\_\_\_

12. IS GHD documented by a negative response to a GH stimulation test?  Yes  No Agent 1: \_\_\_\_\_ Agent 2: \_\_\_\_\_  
 Peak: \_\_\_\_\_ Ng/ml:

13. Document cause of GHD (pituitary/hypothalamic disease, radiation, surgery, trauma): \_\_\_\_\_

**Zorbitive only:**

14. 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 this form to: (866)-399-0929

Pharmacy PA Call Center: (833) 585-4309