Please select medication:

- Norditropin
- Genotropin
- Humatrope
- Nutropin / Nutropin AQ
- Omnitrope
- Saizen
- Zomacton

*Check www.fepblue.org/formulary to confirm which medication is part of the patient’s benefit

Is this request for brand or generic? 
- Brand
- Generic

1. **Non-preferred/non-participating medication request:** For Standard Option patients who would you like to switch to the preferred/participating product, Norditropin? 
- Yes
- No

2. Will the patient be using the requested medication in combination with another somatropin agent such as Serostim, Zorbtyve or any other growth hormone? 
- Yes
- No

3. Is the requested medication being used for cosmetic, anti-aging or athletic performance enhancement? 
- Yes
- No

4. **INITIATION** of therapy with growth hormone? **Please select answer below:**
- YES – this is INITIATION of therapy, please answer the following question:
  a. What is the patient’s diagnosis?
  - Burn wounds (used for promotion of wound healing in burn patients)
  - Growth hormone deficiency
  i. What is the cause of the patient’s growth hormone deficiency? **Select all that apply:**
  - Hypothalamic disease
  - Idiopathic adult-onset
  - Pituitary disease
  - Radiation therapy
  - Surgery
  - Trauma
  - Other cause (please specify): __________________

  ii. Does the patient have a documented result from one of the following growth hormone stimulation tests: Insulin Tolerance Test, Glucagon, Arginine/L-Dopa, or Arginine? **Please select answer below:**
  - Yes: Please select the test and provide the test result below:
    - Insulin tolerance test result: __________ ng/ml
    - Glucagon test result: __________ ng/ml
  - No OR Other Test: Please answer the following questions:
    1) **If Other Test:** please specify test and results: __________________
    2) Does the patient have panhypopituitarism, which is defined as having a deficiency of three or more pituitary hormones such as gonadotropin (LH and/or FS), adrenocorticotropic hormone (ACTH), thyroid-stimulating hormone (TSH), and arginine vasopressin (AVP)?
       - Yes
       - No
    3) Does the patient have documentation of an IGF-1 level below the age and sex appropriate reference range? 
       - Yes
       - No

- Other diagnosis (please specify): __________________

- NO – this is a PA renewal for CONTINUATION of therapy, please answer the following question:
  a. What is the patient’s diagnosis?
  - Burn wounds (used for promotion of wound healing in burn patients)
  - Growth hormone deficiency
  i. What is the cause of the patient’s growth hormone deficiency? **Select all that apply:**
  - Hypothalamic disease
  - Idiopathic adult-onset
  - Panhypopituitarism
  - Pituitary disease
  - Surgery
  - Radiation therapy
  - Trauma
  - Other cause (please specify): __________________

- Other diagnosis (please specify): __________________

**STANDARD OPTION REQUESTS FOR GENOTROPIN, HUMATROPE, NUTROPIN, OMNITROPE, SAIZEN OR ZOMACTON REQUIRE PAGE 2 TO BE COMPLETED**
All requests are subject to approval by a secondary review by a clinical specialist for final coverage determination. Notification will be made at the completion of the review.

Patient Name: ___________________________  DOB: ____________________  Cardholder ID: ____________________________

STANDARD OPTION REQUESTS FOR GENOTROPIN, HUMATROPE, NUTROPIN, OMNITROPE, SAIZEN OR ZOMACTON REQUIRE PAGE 2 TO BE COMPLETED

1. Does the patient have a documented inadequate response to a previous trial of 30 days of Norditropin? ☐ Yes*  ☐ No
   *If YES, please provide specific details regarding inadequate response below:

_______________________________________________________________________

_______________________________________________________________________

2. Does the patient have a documented contraindication and/or known allergy to Norditropin or any of its components? ☐ Yes*  ☐ No
   *If YES, please describe the specific allergy and/or contraindication to Norditropin below:

_______________________________________________________________________

_______________________________________________________________________

3. Is the patient intolerant to or had a confirmed adverse event with Norditropin? ☐ Yes*  ☐ No
   *If YES, please describe the intolerance and/or confirmed adverse event below:

_______________________________________________________________________

_______________________________________________________________________

4. If NO to all questions above, what is the clinical reason/rationale why the member cannot use Norditropin?
   Please give clinical reason/rationale below:

_______________________________________________________________________

_______________________________________________________________________

NOTE: Requests for all adult growth hormone require an additional review prior to a decision being made. Notification will be made at the completion of the review.