Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Growth Hormones (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Growth Hormones (FA-PA).

Drug Name (select from list of drugs shown)

Genotropin (somatropin)	Nutropin (somatropin)	Nutropin AQ (somatropin)
Omnitrope (somatropin)	Saizen (somatropin)	Zomacton (somatropin)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested product being prescribed for a patient with chronic kidney disease?	Y N
2.	Is the requested product Nutropin AQ?	Y N
3.	Is the requested product being prescribed for a patient with Prader-Willi syndrome?	Y N
4.	Is the requested product Genotropin or Omnitrope?	Y N
5.	The preferred products for your patient's plan are Humatrope and Norditropin. Can the patient's treatment be switched to Humatrope or Norditropin?	Y N

6.	Did the patient experience documented inadequate treatment response(s) and/or intolerable adverse event(s) to previous trials with BOTH of the preferred products (Humatrope and Norditropin)? ACTION REQUIRED: IF 'YES', ATTACH CHART NOTES DETAILING THE OUTCOME(S) OF TREATMENT AND/OR INTOLERABLE ADVERSE EVENT(S) EXPERIENCED FROM TREATMENT WITH BOTH OF THE PREFERRED PRODUCTS.	Y N	
7.	Does the patient have a documented contraindication to any of the preferred products (Humatrope or Norditropin) or any of their components? ACTION REQUIRED: IF 'YES', ATTACH DOCUMENTATION DETAILING THE CONTRAINDICATION(S) TO TREATMENT WITH ANY OF THE PREFERRED PRODUCTS.	Y N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date