10/05/2015

Prior Authorization Form

GEHA

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 AQ (somatropin) Omnitrope (somatropin)
Saizen (somatropin) Tev-Tropin (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.

Question		
1. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Y	N
2. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below? (IF YES, PLEASE DOCUMENT DRUG NAME, TRIAL YEAR AND REASON FOR FAILURE) REQUIREMENT: 2 in a class with 2 alternatives: HUMATROPE, NORDITROPIN [If yes, then no further questions.]	Y	N

	Y	N	
3. Does the patient have a documented clinical reason such as expected adverse reaction or contraindication that prevents them from trying the formulary alternatives listed below? (IF YES, PLEASE DOCUMENT THE REASON(S) THE PATIENT CAN NOT TRY THE FORMULARY ALTERNATIVES) Formulary alternatives are: HUMATROPE, NORDITROPIN	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