

Prior Authorization Form

GROWTH HORMONE (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated 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 Nutropin AQ (somatropin).

Patient Information

Patient Name:	<input type="text"/>
Patient Phone:	<input type="text"/>
Patient ID:	<input type="text"/>
Patient Group No:	<input type="text"/>
Patient DOB:	<input type="text"/>

Prescribing Physician

Physician Name:	<input type="text"/>
Physician Phone:	<input type="text"/>
Physician Fax:	<input type="text"/>
Physician Address:	<input type="text"/>
City, State, Zip:	<input type="text"/>

Drug Name (specify drug): Nutropin AQ (somatropin)

Quantity:	Frequency:	Strength:
Route of Administration:	Expected Length of Therapy:	
Diagnosis:	ICD Code:	
Comments:		

Please check the appropriate answer for each applicable question.

- | | | | | |
|--|---|--------------------------|---|--------------------------|
| 1. Has the patient had an inadequate treatment response to a previous list of Humatrope AND Norditropin? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. Does the patient have a documented contraindication to Humatrope OR Norditropin or any of its components? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. Is the patient intolerant to or had a confirmed adverse event with Humatrope AND Norditropin? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. Is growth hormone being prescribed for a patient with chronic kidney disease? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. Is the prescribed growth hormone product Nutropin/ Nutropin AQ? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. Is growth hormone being prescribed for a patient with Prader-Willi syndrome? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. Is the prescribed growth hormone product Genotropin or Omnitrope? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber (Or Authorized) Signature and Date

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