Prior Authorization Form

Zorbtive

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 **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Zorbtive.

Drug Name (select from list of drugs shown)
Zorbtive (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.	Does the patient have a diagnosis of short bowel syndrome?	Y N
	[If no, no further questions.]	
2.	Is the patient currently receiving specialized nutritional support in conjunction with optimal management of short bowel syndrome? Examples of specialized nutritional support are:	Y N
	High complex-carbohydrate, low-fat diet \ TPN, IPN, PPN \ Rehydration solutions \ Electrolyte replacement	
	[If no, no further questions.]	

3.	Does the patient have an active malignancy (either newly diagnosed or recurrent)?	Y N
	[If yes, no further questions.]	
4.	Does the patient have an acute critical illness due to complications following open heart or abdominal surgery, accidental trauma or acute respiratory failure?	Y N
	[If yes, no further questions.]	
5.	Has the patient received at least 4 weeks of Zorbtive therapy?	Y N
	[If no, no further questions.]	
6.	Is the patient continuing to lose weight?	Y N
	[If yes, no further questions.]	
7.	Have the requirement for specialized nutritional support decreased as measured by total volume, total calories, or frequency of infusion?	Y N
	[If no, no further questions.]	
8.	Has the patient received greater than or equal to 8 weeks of Zorbtive therapy?	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