GROWTH HORMONE
PRIOR AUTHORIZATION REQUEST
PHYSICIAN FAX FORM

ONLY the prescriber may complete this form.

BlueCross BlueShield of Florida
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The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Florida web site at http://www.bcbsfl.com.

PATIENT INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:

PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis (ICD-9 code plus description): Date of diagnosis:

Medication Requested: Date GH treatment started:

Information Required for ALL PATIENTS:

1. Please list all reasons for selecting the requested **medication** over alternative GH products (e.g. adverse reaction to other GH products.) _____
2. If the diagnosis is AIDS wasting syndrome, is the patient receiving antiviral therapy? ☐ Yes ☐ No
3. If the diagnosis is chronic renal insufficiency, is the patient post-transplant? ☐ Yes ☐ No
4. If the diagnosis is short bowel syndrome, is the patient receiving nutritional support? ☐ Yes ☐ No

Two Growth Hormone Stim Tests are required for ALL PATIENTS:

Agent 1: Peak:

Agent 2: Peak:

Additional Lab Tests Performed: (e.g. IGF-1, TSH)

Test: Result: Date:

Test: Result: Date:

Test: Result: Date:

Information Required FOR CHILDREN:

Ht (cm) at diagnosis: _____ Ht SD below the mean at diagnosis: _____ OR Ht percentile of normal height: _____

Growth Velocity (cm/yr) at diagnosis: _____

Bone age: _____ Date measured: _____ Patient's age when bone age measured: _____

1. If the patient has been on GH therapy for 6 months or longer, has the diagnosis of GHD been established with complete evaluation in the past? ☐ Yes ☐ No
2. For children >10 years of age, is there X-ray documentation that the epiphyses have not yet closed? ☐ Yes ☐ No

Information Required FOR ADULTS:

1. Does the patient have evidence of hypothalamic-pituitary injury? ☐ Yes ☐ No
2. Does the patient have a medical history of childhood GH deficiency? ☐ Yes ☐ No
3. Does the patient have clinical features associated with GHD (e.g. increased abdominal fat, decreased lean body mass, impaired sense of well-being?) ☐ Yes ☐ No
4. Has the patient been on the GH therapy for 6 months or longer? ☐ Yes ☐ No
   If yes, has the patient improved since the start of GH therapy in any of the following areas: body composition, cardiovascular health, bone mineral density, serum cholesterol, physical strength or quality of life? ☐ Yes ☐ No

Please fax or mail this form to:
Blue Cross and Blue Shield of Florida
c/o Prime Therapeutics LLC, Clinical Review Department
1305 Corporate Center Drive
Eagan, Minnesota 55121

TOLL FREE

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