



**Genotropin**  
(somatropin)  
**Prior Authorization Form**

**Express Scripts**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address	City	State	ZIP
Address	City	State	ZIP
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home		Special Instructions (i.e. Non-English Speaking Patient, etc.)	

Medication:	Diagnosis:
Sig:	Qty:
Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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1. **Will Genotropin be used for the treatment of children with growth failure due to growth hormone deficiency (GHD), Small for Gestational Age, or Idiopathic Short Stature?**  
If yes, continue to #6  
If no, continue to #2
2. **Will Genotropin be used for the treatment of children with growth failure due to Prader-Willi syndrome or Turner syndrome?**  
If yes, continue to #3  
If no, continue to #4
3. **Are diagnoses of Prader-Willi syndrome or Turner Syndrome confirmed by genetic testing?**  
If yes, continue to #6.
4. **Will Genotropin be used for the treatment of adults with either adult onset or childhood onset GHD?**
5. **Does the adult patient with Growth Hormone Deficiency have Insulin-like growth factor-1 (IGF-1) level of less than 84 ng/ml or Growth hormone stimulation tests (e.g., insulin tolerance test (ITT) with Growth Hormone (GH) level of less than 5 mcg/L, Growth Hormone Releasing Hormone (GHRH) with arginine with GH level of less than 4.1 mcg/L)?**

6. Is the prescription written or initiated by an endocrinologist?

7. Will Genotropin be used in patients with one of the following:
- a. In patients with Acute Critical Illness due to complications following open heart surgery, abdominal surgery or multiple accidental trauma, or those with acute respiratory failure
  - b. In children with Prader-Willi syndrome who are severely obese or have severe respiratory impairment
  - c. In patients with Active Malignancy
  - d. In Patients with Active Proliferative or Severe Non-Proliferative Diabetic Retinopathy
  - e. In children with closed epiphyses

8. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u>	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Reviewer's Initials _____	Decision Date _____
Comments _____	

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.