



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Genotropin (somatropin)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name: Member Number: Date of Birth: Group Number: Address: City, State, Zip: Member Phone:	Prescriber Name: Fax: Phone: Office Contact: NPI: State Lic ID: Address: City, State, Zip:
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. What is the requested duration of therapy? 12 months or less More than 12 months
Q2. Is the patient compliant with therapy? Yes No
Q3. Has the patient tolerated the medication without any significant side effects (such as leukemia, antibody production)? Yes No
Q4. For adults, have you attached the updated IGF-1? Labs MUST be attached. Yes No
Q5. For children, have you attached the growth chart, height, chronological age, bone age, growth rate, and growth hormone levels? Growth chart, labs, and notes MUST be attached. Growth hormone levels are not required for Prader-Willi or Turner Syndrome. Yes No
Q6. Comments:
Q7. Deliver to: Physician's Office Home Delivery
Q8. Delivery date needed:

Physician Signature

Date