



**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**Norditropin (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:

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. What is the prescriber's specialty?

Endocrinologist      Internal Medicine      Other

Q3. If Other, please specify:

Q4. Is the patient compliant with the therapy?

Yes      No

Q5. Has the patient experienced any significant side effects (such as leukemia, antibody production)?

Yes      No

Q6. 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. For Turner syndrome, growth hormone levels not required.

Yes      No

Q7. For adults: Have you attached the updated IGF-1? Labs must be attached.

Yes      No

Q8. Comments:

Q9. Deliver to:

Physician's Office      Home Delivery

Q10. Delivery date needed:



**PRIOR AUTHORIZATION REQUEST FORM**

**EOC ID:**

**Norditropin (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:**

**Prescriber Name:**

--	--

---

**Physician Signature**

**Date**

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.