



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Saizen (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 print clearly.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Physician Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic. Id:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please answer the following questions and sign below:

Q1. What is the requested duration of therapy?

12 months or less More than 12 months

Q2. What is the patient's age?

Less than 18 years 18 years or older

Q3. What is the diagnostician's and requestor's specialties?

Endocrinologist Internal Medicine Other

Q4. If OTHER, please specify:

Q5. What is the patient's diagnosis?

Growth failure due to an inadequate secretion of endogenous growth hormone

Growth failure due to Prader-Willi syndrome (PWS)

Growth failure in children born small for gestational age (SGA) who fail to manifest catch-up growth by age 2

Short stature associated with Turner syndrome

Idiopathic short stature, also called non-growth hormone-deficient short stature

Treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation

Other

Q6. If Other, Please specify:

Q7. Has the patient tried and failed therapy using Norditropin?

Yes No

Q8. Deliver to:

Physician's Office Home Delivery

Q9. Delivery date needed:



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Patient Name:

Physician Name:

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Physician Signature

Date

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