

**Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Human Growth Hormone**

**Somatropin (Genotropin®, Norditropin®, Nutropin®, Nutropin® AQ,
Humatrope®, Serostim®, Saizen®, Somatrem, TevTropin®, Zorbtive, Accretropin,
Omnitrope, Valtropin, Protropin®)
BCBSVT and TVHP Fax # (888)–255-1006**

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 BCBSVT/TVHP Member ID#: _____ Date of birth: _____
 Provider Name: _____ Provider Phone number: _____
 Provider Fax number: _____ PCP Name: _____
 Pt. Weight in Kg: _____ Patient height: _____

Indicate which agent is being requested:	
Genotropin® - Preferred	<input type="checkbox"/>
Norditropin® - Preferred	<input type="checkbox"/>
Nutropin®	<input type="checkbox"/>
Nutropin® AQ	<input type="checkbox"/>
Humatrope®	<input type="checkbox"/>
Serostim®	<input type="checkbox"/>
Saizen®	<input type="checkbox"/>
Protropin®	<input type="checkbox"/>
Zorbtive®	<input type="checkbox"/>
TevTropin®	<input type="checkbox"/>
Accretropin®	<input type="checkbox"/>
Omnitrope®	<input type="checkbox"/>
Valtropin®	<input type="checkbox"/>

INDICATIONS FOR USE

	<u>YES</u>	<u>NO</u>
1. Patient is a child diagnosed with growth failure due to a lack of growth hormone secretion., If yes, continues to 1a	<input type="checkbox"/>	<input type="checkbox"/>
a) Patient's growth velocity is \leq 25th percentile for bone age.	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient has abnormally low values (< 10 ng/ml) of serum GH on two provocative tests.	<input type="checkbox"/>	<input type="checkbox"/>
c) Patient's height is > 2.5 Standard Deviations below the mean height for normal children of the same age	<input type="checkbox"/>	<input type="checkbox"/>
d) Have conditions that depress GH secretion been ruled out in this patient (e.g. hypothyroidism, chronic nonendocrine disease, or psychosocial deprivation)?	<input type="checkbox"/>	<input type="checkbox"/>
Continue to #7.		

2. Patient has growth failure due to chronic renal insufficiency (glomerular filtration rate below 70 ml/min/1.73 m ²). If yes, continues to 2a	<input type="checkbox"/>	<input type="checkbox"/>
a) Patient is in good metabolic control and is able to maintain adequate nutritional intake.	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient has no obvious clinical evidence of another unrelated etiology for growth retardation.	<input type="checkbox"/>	<input type="checkbox"/>
c) Patient's height is > 2 Standard Deviations below the mean height for normal children of the same age.	<input type="checkbox"/>	<input type="checkbox"/>
Continue to #7.		

3. Patient has Turner's Syndrome. If yes, continues to 3a	<input type="checkbox"/>	<input type="checkbox"/>
a) There is chromosomal information consistent with the disease (45, X karyotype or others). Continue to #7.	<input type="checkbox"/>	<input type="checkbox"/>
4. Patient has somatropin deficiency and is an adult. If yes, continues to 4a	<input type="checkbox"/>	<input type="checkbox"/>
a) Patient has had a negative response to a standard growth hormone stimulation test.	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient has pituitary disease, hypothalamic disease, or previous surgery or radiation therapy to those areas.	<input type="checkbox"/>	<input type="checkbox"/>
c) Patient was growth hormone deficient as a child and has had somatropin deficiency confirmed as an adult. Continue to #8.	<input type="checkbox"/>	<input type="checkbox"/>
5. Patient has been diagnosed with AIDS wasting or cachexia. If yes, continues to 5a	<input type="checkbox"/>	<input type="checkbox"/>
a) Drug being used is Serostim®	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient has had a previous trial with megestrol acetate (Megace®).	<input type="checkbox"/>	<input type="checkbox"/>
6. Patient has been diagnosed with short bowel syndrome. If yes, continues to 6a	<input type="checkbox"/>	<input type="checkbox"/>
a) Drug being used is Zorbtive®	<input type="checkbox"/>	<input type="checkbox"/>
7. Does Patient have closed epiphyses?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has patient had a trial of Norditropin?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has patient had a trial of Genotropin?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does Patient have sensitivity to benzyl alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does Patient have evidence of tumor activity or active neoplasia?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does Patient have sensitivity to m-cresol or glycerin and is receiving Humatrope®?	<input type="checkbox"/>	<input type="checkbox"/>

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____
By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

Will Prescription be dispensed at (circle one): **Provider Office** **Network Pharmacy**

References

- Olin BR, ed. Drug Facts and Comparisons (Updated Monthly). Facts and Comparisons. St. Louis, 1999.
- AACE clinical practice guidelines for growth hormone use in adults and children. Endocrine Practice. 1998;4(3):165-173.
- Guidelines for the use of growth hormone in children with short stature: a report by the Drug and Therapeutics Committee of the Lawson Wilkins Pediatric Endocrine Society. J Pediatr 1995;127:857-867.
- Vance ML, Mauras N. Growth hormone therapy in adults and children. NEJM 1999;Oct 14:1206-1216.

