CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Human Growth Hormone (HGH)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Parent/Guardian: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____ Primary Language: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
NPI #: _____
DEA #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card:	Name of Insurer:		ID#:		BIN:		PCN:		Group:
Primary Insurance:	Subscriber:		ID#:		Name of Insurer:	Blue Cross Blue Shield of RI			Phone:
Secondary Insurance:	Subscriber:		ID#:		Name of Insurer:				Phone:

Diagnosis (ICD-9 Code):

☐ 253.2 Panhypopituitarism
☐ 253.7 Iatrogenic Pituitary Disorder
☐ 253.3 Isolated Growth Hormone Deficiency
☐ 783.43 ☐ Idiopathic Short Stature ☐ Small for Gestational Age
☐ 585 Chronic Renal Failure/Insufficiency
☐ 758.6 Gonadal Dysgenesis (Turner Syndrome)
☐ 759.81 Prader-Willi Syndrome
☐ 193 Malignant Neoplasm
☐ 799.4 Cachexia ☐ HIV Patient with Wasting Syndrome
☐ Short Bowel Syndrome (Please include ICD-9 code) _____
☐ Other: _____
• Date of Diagnosis: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Preferred HGH:
☐ Nutropin
☐ Nutropin AQ

Non-Preferred HGH:
☐ Genotropin ☐ Humatrope
☐ Norditropin ☐ Omnitrope
☐ Saizen ☐ Tev-Tropin
☐ Serostim
☐ Zorbtive

Non-Preferred HGH agents require a trial of Nutropin or Nutropin AQ
***(except* Serostim for HIV wasting or Zorbtive for SBS)**
Check applicable boxes:
• Patient had a confirmed adverse event with Nutropin/Nutropin AQ ☐ Yes ☐ No
If yes, please provide adverse event: _____

For growth failure associated with GHD:

• Does patient have hypopituitarism or multiple pituitary hormone deficiency? ☐ Yes ☐ No
Please indicate what Growth Hormone Stimulation Tests have been performed: ☐ Insulin Induced Hypoglycemia ☐ Arginine ☐ Glucagons ☐ Clonidine ☐ L-dopa ☐ Propranolol ☐ Other: _____

Date: _____
Patient's Chronological Age: _____
Patient's Current Height: _____
Patient's Mid-parental Height: _____
Patient's Bone Age: _____

List **and attach** copy of Growth Hormone Stimulation Test Results **and** Reagents Used

Reagent 1:		Reagent 2:	
Results #1:		Results #1:	
Results #2:		Results #2:	
Results #3:		Results #3:	
Results #4:		Results #4:	

• How many standard deviations (SD) below the mean is this patient's estimated final adult height based on bone age? _____
• What is this patient's growth velocity (measured at least over 1 year)? _____
• Are epiphyses open? ☐ Yes ☐ No

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For children born Small for Gestational Age (SGA):

- At birth, how many standard deviations (SD) below the mean for gestational age were the following parameters?
  - Length: _____ • Weight: _____
- Is patient 2 years of age or older with a current height ≥ 2 SDs below mean for age and sex? ☐ Yes ☐ No

Are there any other factors that may contribute to the shortness of stature such as growth inhibiting medications, chronic diseases, endocrine disorders, emotional deprivation, or syndromes? ☐ Yes ☐ No

- If yes to the above, please list: _____

For AIDS Wasting Syndrome:

- Is patient currently receiving antiretroviral therapy? ☐ Yes ☐ No
- Could weight loss be explained by concurrent illness other than HIV? ☐ Yes ☐ No
- What baseline percentage weight loss has the patient experienced? _____

For Short Bowel Syndrome (SBS):

- Is patient currently receiving specialized nutritional support in conjunction with optimal SBS management? ☐ Yes ☐ No

Review for medical necessity for children should occur annually:

Result of the first year of therapy:

- Has there been a doubling of the pre-treatment growth rate? ☐ Yes ☐ No
- Has there been an increase in pre-treatment growth rate of 3 cm per year or more? ☐ Yes ☐ No

For therapy continuing past the first year:

- Has the growth rate remained above 2.5 cm per year? ☐ Yes ☐ No

For children over 10 years of age:

- Has there been an x-ray report that shows the epiphyses have not yet closed? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Nutropin®	☐ 5mg Vial ☐ 10mg Vial			
☐ Nutropin AQ®	☐ 10 Vial ☐ 5mg NuSpin ☐ 10 mg Pen ☐ 10mg NuSpin ☐ 20 mg Pen ☐ 20mg NuSpin			
☐ Serostim®	☐ 4 mg Vial ☐ 6 mg Vial ☐ 5 mg Vial			
☐ Zorbtive®	☐ 8.8mg Vial			
☐				

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)