Health Partners Plans

HEALTH PARTNERS PLANS

PRIOR AUTHORIZATION REQUEST FORM

Growth Hormones Renewal

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

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
HPP Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Address:	NPI: Promise ID:
City, State ZIP:	Prescriber PA PROMISe ID:
Patient Primary Phone:	Address:
Line of Business: ☐ Medicaid ☐ CHIP	City, State ZIP:
	Specialty/facility name (if applicable):

☐ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Is the patient over the age of 14 (if female) or 15 (if male)?

☐ Yes ☐ No

Q3. Is there documentation of continued linear growth, linear growth potential remaining, and/or open epiphyses?

☐ Yes ☐ No

Q4. Has the patient tolerated the medication without any significant side effects?

☐ Yes ☐ No

Q5. Is the patient compliant with therapy?

☐ Yes ☐ No

Q6. Is documentation attached including the growth chart, height, chronological age, growth velocity, and bone age, growth rate, and IGF-1 level? Growth chart, labs, and notes must be attached.

☐ Yes ☐ No

Q7. Has the member experienced an annualized growth rate of at least 2-2.5cm/year?

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Patient Name: **Prescriber Name:**

☐ Yes ☐ No

Q8. Is the patient's IGF-1 level within the appropriate reference range? Documentation must be attached.

☐ Yes ☐ No

Q9. Is there a plan to increase or decrease the dose of growth hormone as appropriate to target an IGF-1 level within the appropriate reference range?

☐ Yes ☐ No

Q10. For Adult Patient: Has the patient tolerated the medication without any significant side effects?

☐ Yes ☐ No

Q11. Is the patient compliant with therapy?

☐ Yes ☐ No

Q12. Is the patient's IGF-1 level within the appropriate reference range? Documentation must be attached.

☐ Yes ☐ No

Q13. Is there a plan to increase or decrease the dose of growth hormone as appropriate to target an IGF-1 level within the appropriate reference range?

☐ Yes ☐ No

Q14. Requested Duration:

☐ 12 Months

Q15. Additional Information:

Prescriber Signature

Date

Updated 2018

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