TRICARE Prior Authorization Request Form for
somapacitan-beco injection **(Sogroya)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

Fax Completed Form and Applicable Progress Notes to:
(410) 424-4037

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires in 1 year; provider must fill out a new PA.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.	☐ Acknowledged Proceed to question **2**	
2. Does the patient have a contraindication to Norditropin?	☐ Yes Proceed to question **4**	☐ No Proceed to question **3**
3. Has the patient experienced an adverse reaction(s) to Norditropin, Omnitrope, AND Zomacton not expected with the requested medication? Note: all possible preservative formulations are available between Norditropin, Omnitrope and Zomacton. Note that patient preference for a particular device is insufficient grounds for approval of an NF agent.	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient require a less than daily dosing regimen due to needle intolerance or aversion?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Will the requested medication be used in combination with multiple somatropin agents?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**
6. Is the patient a pediatric patient between the ages of 2.5 to 17 years of age?	☐ Yes Proceed to question **7**	☐ No Proceed to question **9**

7. Is the requested medication being used for the indication of growth failure due to an inadequate secretion of endogenous growth hormone (GH) in pediatric patients? Note: Non-FDA-approved uses are not approved, including Idiopathic Short Stature, normal aging process, obesity, and depression.	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the requested medication prescribed by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the requested medication being used for adult growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery or radiation therapy that was acquired as an adult or diagnosed during childhood? Note: Non-FDA-approved uses are not approved, including Idiopathic Short Stature, normal aging process, obesity, and depression.	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Was the requested medication written by or in consultation with an appropriate specialty (endocrinologist, infectious disease specialist, general surgeon or gastroenterologist)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[15 November 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: