

TRICARE Prior Authorization Request Form for
Growth Hormone



JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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 after one year.

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 indicate the specific product for which prior authorization is requested: _____
The DoD step preferred (formulary) growth hormone product is Norditropin FlexPro.
 Formulary but non-step preferred growth hormone products: Zomacton, and Omnitrope.
 Non – formulary growth hormone products: Genotropin, Humatrope, Nutropin AQ NuSpin, Ngenla, Serostim, Zorbtive, and Saizen.

Step 3 Please complete the clinical assessment

1. Which medication is being requested?	<input type="radio"/> Ngenla – Proceed to question 2 <input type="radio"/> All other medications – Proceed to question 9	
2. The provider acknowledges that Norditropin is the Department of Defense's preferred somatropin agent.	<input type="radio"/> Acknowledged Proceed to question 3	
3. How old is the patient?	<input type="radio"/> Greater than or equal to 3 years of age and less than or equal to 17 years of age – Proceed to question 4 <input type="radio"/> Other – STOP Coverage not approved	
4. Is Ngenla being used for the indication of growth failure due to an inadequate secretion of endogenous growth hormone (GH) in pediatric patients?	<input type="radio"/> Yes Proceed to question 5	<input type="radio"/> No STOP Coverage not approved
5. Is the prescription written by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?	<input type="radio"/> Yes Proceed to question 6	<input type="radio"/> No STOP Coverage not approved

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<p>6. Does the patient have a contraindication to Norditropin?</p>	<input type="radio"/> Yes Proceed to question 8	<input type="radio"/> No Proceed to question 7
<p>7. Has the patient experienced an adverse reaction to Norditropin, Omnitrope, AND Zomacton not expected with Ngenla? 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.</p>	<input type="radio"/> Yes Proceed to question 8	<input type="radio"/> No STOP Coverage not approved
<p>8. Does the patient require a less than daily dosing regimen due to needle intolerance or aversion?</p>	<input type="radio"/> Yes Sign and date below	<input type="radio"/> No STOP Coverage not approved
<p>9. Is the patient greater than or equal to 18 years of age?</p>	<input type="radio"/> Yes Proceed to question 13	<input type="checkbox"/> No Proceed to question 10
<p>10. Is the patient a child with one of the following conditions?</p> <ul style="list-style-type: none"> <input type="radio"/> Growth Hormone Deficiency <input type="radio"/> Small for gestational age <input type="radio"/> Chronic renal insufficiency associated with growth failure <input type="radio"/> Prader-Willi Syndrome (in patients with a negative sleep study for obstructive sleep apnea) <input type="radio"/> Turner Syndrome <input type="radio"/> Noonan's Syndrome <input type="radio"/> Short stature homeobox gene (ShoX) gene mutation 	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No Proceed to question 11
<p>11. For patients younger than 18 years of age who do not have one of the indications mentioned above, please provide the diagnosis.</p>	<hr style="width: 20%; margin: 0 auto;"/> <p>Please write-in the diagnosis</p> <p>Proceed to question 12</p>	
<p>12. Is the prescription written by or in consultation with a pediatric endocrinologist or nephrologist who recommends therapeutic intervention and will manage treatment?</p>	<input type="radio"/> Yes Proceed to question 16	<input type="radio"/> No STOP Coverage not approved
<p>13. Is the patient an adult with growth hormone deficiency as a result of pituitary disease, hypothalamic disease, trauma, surgery, or radiation therapy, acquired as an adult or diagnosed during childhood?</p>	<input type="radio"/> Yes Proceed to question 15	<input type="radio"/> No Proceed to question 14

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14. Does the patient have HIV/AIDS wasting/cachexia or Short Bowel Syndrome?	<input type="radio"/> Yes Proceed to question 15	<input type="radio"/> No STOP Coverage not approved
15. Is the prescription written by or in consultation with an appropriate specialist (endocrinologist, infectious disease specialist, general surgeon, or gastroenterologist)?	<input type="radio"/> Yes Proceed to question 16	<input type="radio"/> No STOP Coverage not approved
16. Which medication is being requested?	<input type="radio"/> Norditropin FlexPro - Sign and date below <input type="radio"/> Genotropin, Humatrope, Nutropin AQ Nuspin, Ngenla, Saizen, Zorbtive, Serostim, Omnitrope or Zomacton – Proceed to 17	
17. Does the patient have a contraindication to Norditropin FlexPro?	<input type="radio"/> Yes Sign and date below	<input type="radio"/> No Proceed to question 18
18. Has the patient experienced an adverse reaction to Norditropin FlexPro that is not expected with the non-step preferred product (Genotropin, Humatrope, Nutropin AQ Nuspin, Ngenla, Saizen, Zorbtive, Omnitrope, Serostim, or Zomacton)?	<input type="radio"/> Yes Sign and date below	<input type="radio"/> No STOP Coverage not approved
<p>Please note that use of a Growth Stimulating Agent is not approved for the following: idiopathic short stature, the normal ageing process, obesity, or depression, other off-label uses (for example, non-alcoholic fatty liver disease, cirrhosis, mild cognitive impairment, etc.) or concomitant use of multiple Growth Stimulating Agents.</p>		

Step 4 I certify that the above is correct to the best of my knowledge (Please sign and date):

Prescriber Signature

Date

[14 Feb 2024]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: