

**Health New England
Medication Request Form (MRF)/Prescription Request
Growth Hormone Pedi**

Prior Authorization

- | | |
|--------------------------|---|
| <input type="checkbox"/> | Preferred drug accepted.
New verbal order
authorized. |
| <input type="checkbox"/> | Preferred drug rejected by
physician. |

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

DO NOT WR FOR IN
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Growth Hormone. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

Medication Request Information (please complete each section of this form prior to transmittal):

J-code: 1 unit = 500mg; J1567- Non-lyophilized (liquid); J1566- lyophilized (powder)

Patient Information (all required)		Physician Information (all required)	
Patient Name:		Physician Name:	
Gender:		Specialty:	
Patient Cell Phone #: () -		NPI #:	
Patient HNE ID#:		HNE Provider #:	
Patient Date of Birth:		DEA #:	
Allergies:		Telephone #: () -	
		Fax # (required): () -	
Drug Information			
Preferred Drug: <input type="checkbox"/> Norditropin			
Requested Drug/Strength/Form:			
Dose, Directions, and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician Signature:		Date:	
Indication (required):			
<input type="checkbox"/> Diagnosis: _____			
<input type="checkbox"/> Bone age: _____ Date: _____ Height: _____ Date: _____			
<input type="checkbox"/> Growth rate in past year: _____			
Test Results (required):			
<input type="checkbox"/> GH stimulation tests performed and peak results: _____ Date: _____			
<input type="checkbox"/> Random growth hormone level (applicable to infants only): _____ Date: _____			
<input type="checkbox"/> Serum IGF-1 or IGF-BP3: _____ Reference Range: _____ Date: _____			
<input type="checkbox"/> Other causes of low IGF-1/IGF-BP-3 levels have been ruled out: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<input type="checkbox"/> Diagnosis confirmed by chromosomal analysis: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Necessity:			
• Patient has multiple pituitary deficiencies or is status post cranial irradiation:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Demonstrated short stature/growth failure (height < -2SDS below the mean for age and gender or < 3 rd %ile):		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Significant delay in growth velocity:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Complications of chronic renal insufficiency have been corrected:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Patient is status post transplant:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Patient is being considered for second transplant:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Malignant condition ruled out:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
• Patient with Prader-Willi syndrome has experienced an increase in lean body mass/decrease in fat mass on GH therapy:		<input type="checkbox"/> Yes	<input type="checkbox"/> No