

**Physician's Prior Authorization Questionnaire
Norditropin®**

Patient:

ID#:

DOB:

Patient Address:

Norditropin® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

Is this an initial request for approval? Yes No

If Yes, answer questions 1 thru 10 only and submit this form.

Is this a request for continued approval? Yes

If Yes, answer questions 11 thru 13 only and submit this form.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____
2. What is the patient's height percentile? _____
3. What is the patient's growth rate in centimeters per year? _____
4. Has epiphyseal fusion occurred? Yes No
5. Has the patient had intracranial surgery or irradiation? Yes No
6. Does the patient have chronic renal failure? Yes No
If Yes:
 - Is the patient a candidate for transplantation? Yes No
 - Is the growth hormone being administered prior to transplantation? Yes No
7. Does the patient have HIV wasting syndrome? Yes No
If Yes, please specify the date that treatment with growth hormone will be/was initiated:

8. Is the patient's growth rate less than the fiftieth percentile for age? Yes No
9. Please list the patient's weight and height: Weight _____ Height _____
10. Please furnish the date and results of all human growth hormone test performed prior to the initiation of Human Growth Hormone therapy. _____

11. Has the patient had significant side effects? Yes No
If Yes, please list them: _____

12. Has the patient been compliant with therapy? Yes No

13. Has the patient had growth velocity of >2.00 cm/year in the first 6 months and 4.5 cm/year thereafter?

Yes No

➤ **If Yes, please submit documentation of growth velocity since initiation of therapy.**

Norditropin® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx