

**GROWTH HORMONE
PREAUTHORIZATION REQUEST
PHYSICIAN FAX FORM**



**BlueCross BlueShield
of Illinois**

ONLY the prescriber may complete and fax this form.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcbsil.com

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis (ICD-9 code plus description):	Date of diagnosis:
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Medication Requested:	Date GH treatment started:
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Information Required for ALL PATIENTS:

- If the diagnosis is AIDS wasting syndrome, is the patient receiving antiviral therapy?..... Yes No
- If the diagnosis is chronic renal insufficiency, is the patient post-transplant?..... Yes No
- If the diagnosis is short bowel syndrome, is the patient receiving nutritional support?..... Yes No

Two Growth Hormone Stim Tests are required for ALL PATIENTS:

Additional Lab Tests Performed: (e.g. IGF-1, TSH)

Agent 1:	Peak:	Test:	Result:	Date:
Agent 2:	Peak:	Test:	Result:	Date:

Information Required FOR CHILDREN:

Ht (cm) at diagnosis: _____ Ht SD below the mean at diagnosis: _____ OR Ht percentile of normal height _____
 Growth Velocity (cm/yr) at diagnosis: _____
 Bone age: _____ Date measured: _____ Patient's age when bone age measured: _____

- If the patient has been on GH therapy for 6 months or longer, has the diagnosis of GHD been established with complete evaluation in the past? Yes No

Information Required FOR ADULTS:

- Does the patient have evidence of hypothalamic-pituitary injury? Yes No
- Does the patient have a medical history of childhood GH deficiency ? Yes No
- Does the patient have clinical features associated with GHD (e.g. increased abdominal fat, decreased lean body mass, impaired sense of well-being?)..... Yes No
- Has the patient been on the GH therapy for 6 months or longer? Yes No
 If yes, has the patient improved since the start of GH therapy in any of the following areas: body composition, cardiovascular health, bone mineral density, serum cholesterol, physical strength or quality of life? Yes No

Please fax or mail this form to:

Blue Cross and Blue Shield of Illinois
 c/o Prime Therapeutics LLC, Clinical Review Department
 1020 Discovery Road, No. 100
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130

Phone: 800.285.9426

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