



GROWTH STIMULATING AGENTS
Prior Authorization/Prescription/Patient Enrollment Form
 Complete form in its entirety and fax to number listed below

1 PATIENT INFORMATION			
Last Name		First Name	Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #	
Allergies: <input type="checkbox"/> NKA or _____			
Street Address		City	
State	County	Zip Code	
Home Phone		Cell Phone	
Parent/Guardian		Day Telephone	Night Telephone
Emergency Contact		Relationship	Telephone

2 PRESCRIBER INFORMATION			
Prescriber's Name		NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name	
Street Address		City	
State	County	Zip Code	
Contact Person at Office		Prescriber Specialty	



Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

3 Department of Vermont Health Access GROWTH STIMULATING AGENTS PRIOR AUTHORIZATION REQUEST	
Patient Diagnosis: _____	
Requested DVHA PREFERRED Growth Stimulating Agent <input type="checkbox"/> Norditropin®	
Growth Hormone Stimulation Test # 1	Test: _____ result: _____
Growth Hormone Stimulation Test # 2	Test: _____ result: _____
Patient's Height:	_____
Patient's Bone Age:	_____
Patient's Chronological Age:	_____
Growth Velocity:	_____
IGF-1 results:	_____
Please explain the medical necessity for a ' NON-PREFERRED ' product: <input type="checkbox"/> Genotropin® <input type="checkbox"/> Humatrope® <input type="checkbox"/> Omnitrope® <input type="checkbox"/> Nutropin® <input type="checkbox"/> Saizen® <input type="checkbox"/> Tev-Tropin® Medical justification: _____ _____	
Request is for a ' SPECIALIZED INDICATION ' product: (Criteria in Clinical Criteria Manual) <input type="checkbox"/> Increlex® <input type="checkbox"/> Serostim® <input type="checkbox"/> Zorbitive®	
Other information/ Prescriber comments: _____ _____	
4 PRESCRIPTION	
<input type="checkbox"/> Norditropin® FlexPro 5 mg/1.5 ml <input type="checkbox"/> Norditropin® FlexPro 10 mg/1.5 ml <input type="checkbox"/> Norditropin® FlexPro 15 mg/1.5 ml <input type="checkbox"/> Norditropin® NordiFlex 30 mg/3 ml <input type="checkbox"/> Other Product: (Please Specify) _____	
Dosage Form / Strength: _____	
Dose/Route & Frequency (Sig): _____	
Dispense Quantity: <input type="checkbox"/> One month supply or _____ Refill X _____	
<input type="checkbox"/> Needles/syringes: quantity sufficient for drug supply with refills as above	
Deliver product to: <input type="checkbox"/> Patient's home <input type="checkbox"/> MD office <input type="checkbox"/> Clinic	
Prescriber's Signature: _____ Date: _____	