

# CIGNA Specialty Pharmacy Services Growth Hormone Fax Order Form



Please deliver by: \_\_\_\_\_

Requests received after 4 p.m. CT will begin processing the following business day

FAX: 800.351.3616  
PHONE: 800.351.3606

Order #: \_\_\_\_\_ Referral Source Code: 652

PATIENT INFORMATION (Please Print)		PHYSICIAN INFORMATION	
PATIENT NAME:		DATE OF BIRTH :	NAME:
HEALTH CARE ID #:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F	DEA: _____ NPI: _____
HOME PHONE: _____ ALT PHONE: _____		TELEPHONE: _____	FAX: _____
ADDRESS: (Street) (City) (State) (Zip Code)		<b>SHIP MEDICATIONS TO:</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Member's Home Please provide all available patient phone numbers in Patient Information section at left. This is <b>REQUIRED</b> for scheduling delivery. * Is your fax machine kept in a secure location? <input type="checkbox"/> Yes <input type="checkbox"/> No * May we fax our response to your office? <input type="checkbox"/> Yes <input type="checkbox"/> No	
ALLERGIES:		<b>HOME HEALTH SERVICES REQUIRED?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	
<small>If no allergies are specified, for new customers this indicates no known allergies and for existing customers this indicates no change from information provided to CIGNA Specialty Pharmacy previously.</small>		LOCAL HOME HEALTH AGENCY:	TELEPHONE:

## PRESCRIPTION INFORMATION

**\*HUMATROPE® (Somatropin - J2941) \*CIGNA Preferred\***  
 5 mg Vial  6 mg Cartridge  12 mg Cartridge  24 mg Cartridge

**\*SAIZEN® (Somatropin - J2941) \*CIGNA Preferred\***  
 5 mg (15IU) Vial Does pt use with Cool Click 2® device?  **OR** Needle and Syringe   
 8.8 mg (26.4IU) Vial Does pt use with Cool Click 2® device?  **OR** Needle and Syringe   
 8.8 mg (26.4IU) Click.Easy® Cartridge Does pt use with One.Click® device  **OR** Easy Pod device   
**Devices and supplies for these devices are only available through Connections for Growth 1-800-582-7989**

**OTHER:**

<b>DIRECTIONS:</b> Inject _____ mg SQ <input type="checkbox"/> Daily <b>OR</b> _____ days per week Mix vial with _____ cc diluent Volume to inject _____ cc	<b>QTY/REFILLS:</b> <input type="checkbox"/> 1 month supply _____ refills <input type="checkbox"/> 3 month supply _____ refills <input type="checkbox"/> Other: _____ QTY _____ refills <small>*3 month supplies of medications can result in lower copays for the member*</small>
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**SUPPLIES NEEDED (if medication is to be administered in patient's home):**

**Mixing Syringes:**  3cc 22g 1"  Other:

**Insulin Administration Syringes:**  
 Select Syringe Size:  3/10cc  1/2cc  1cc  
 Select Needle Size:  30g 1/2"  31g 5/16" short needle

**Pen Needles (pen needles for Saizen® should be obtained through Connections for Growth 1-800-582-7989):**  
 Novofine 30g 1/3" (8MM)  BD 31g 5/16" (8MM) short pen needles  Other:  
 Sharps Container  Swabs

PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

PHYSICIAN'S PRINTED NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**" on the prescription

**Clinical Information**

If requesting Genotropin®, Norditropin®, Nutropin®, Nutropin AQ®, Omnitrope®, or Tev-Tropin, please answer the following questions:

1. Has the patient had failure or intolerance to Humatrope? Yes No  
If yes, please specify specific failure or intolerance: \_\_\_\_\_
2. Has the patient had failure or intolerance to Saizen? Yes No  
If yes, please specify specific failure or intolerance: \_\_\_\_\_
3. Does the patient have a contraindication to switching to CIGNA's current preferred products, Saizen or Humatrope? Yes No  
If yes, please specify the contraindication to both products: \_\_\_\_\_

**PLEASE INCLUDE DOCUMENTED PROGRESSION OF DISEASE/PRIOR THERAPIES FOR JUSTIFICATION FOR THE DRUG:**

**Please specify the following:**

Has this patient been treated with growth hormone in the past?  Yes  No  
 If Yes, what was the patient's pre-treatment age?  
 If Yes, what date was growth hormone therapy started?

**Questions for Pediatric Patients**

Has this patient been evaluated by an endocrinologist (initially and annually)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
What was the patient's <b>pre-treatment height</b> ?	Answer/Details:
What was the patient's <b>pre-treatment height velocity</b> ?	Answer/Detail:
Are the patient's epiphyses open? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:

**Growth Hormone Deficiency in Children**

Additional Question(s)	Does this patient have any of the following CNS pathology? Please check any options that apply: <input type="checkbox"/> Hypoplasia of pituitary gland <input type="checkbox"/> Empty sella syndrome <input type="checkbox"/> Craniofacial developmental defects <input type="checkbox"/> Septo-optic dysplasia <input type="checkbox"/> Interruption of pituitary stalk <input type="checkbox"/> Pituitary or hypothalamic tumors <input type="checkbox"/> History of irradiation <input type="checkbox"/> Multiple pituitary hormone deficiency <input type="checkbox"/> Proven genetic defect affect growth hormone axis	Additional Details:																								
	Has this patient had a growth hormone response of less than 10ng/mL to at least TWO provocative stimuli? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please note that only 1 stim test is required for children with CNS pathology.</i>																									
	Which provocative stimuli tests were performed? Please specify the date and lab value of tests performed.	Additional Details:																								
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 35%;">Stimuli</th> <th style="width: 20%;">Lab Value</th> <th style="width: 40%;">Date Taken</th> </tr> </thead> <tbody> <tr> <td align="center"><input type="checkbox"/></td> <td align="center">Insulin</td> <td></td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center">Levodopa</td> <td></td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center">L-Arginine</td> <td></td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center">Clonidine</td> <td></td> <td></td> </tr> <tr> <td align="center"><input type="checkbox"/></td> <td align="center">Glucagon</td> <td></td> <td></td> </tr> </tbody> </table>		Stimuli	Lab Value	Date Taken	<input type="checkbox"/>	Insulin			<input type="checkbox"/>	Levodopa			<input type="checkbox"/>	L-Arginine			<input type="checkbox"/>	Clonidine			<input type="checkbox"/>	Glucagon			
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<input type="checkbox"/>	Clonidine																									
<input type="checkbox"/>	Glucagon																									

	Have other pituitary hormone deficiencies been ruled out or corrected (including thyroid, cortisol and sex hormones)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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**Please attach growth curve charts and include all lab levels. These items are required for review of this request.**

<input type="checkbox"/>	<b>Small for Gestational Age</b>	
Additional Question(s)	What is this patient's <b>gestational age</b> ?	Answer/Detail:
	What is this patient's <b>birth weight</b> ?	Answer/Detail:
	What is this patient's <b>birth length</b> ?	Answer/Detail:
	What is this patient's <b>height at age 2?</b>	Answer/Detail:
<b>Please attach growth curve charts. These items are required for review of this request.</b>		
<input type="checkbox"/>	<b>Growth Delay Secondary to Chronic Kidney Disease</b>	
	Does this patient have renal function at stage 2 chronic kidney disease (or GFR from 60-89 ml/min/1.73m <sup>2</sup> )? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
<b>Please attach growth curve charts. These items are required for review of this request.</b>		
<input type="checkbox"/>	<b>Turner's Syndrome</b>	
Additional Question(s)	Has the diagnosis of Turner's Syndrome been established by genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please note that documentation of genetic testing is required for review of this request.</i>	Additional Details:
	<b>Please attach growth curve charts and documentation of genetic testing. These items are required for review of this request.</b>	
<input type="checkbox"/>	<b>Panhypopituitarism</b>	
Additional Question(s)	Which of the following anterior pituitary hormones are absent in this patient? Please mark all that apply. <input type="checkbox"/> Luteinizing Hormone (LH) <input type="checkbox"/> Follicle Stimulating Hormone (FSH) <input type="checkbox"/> Thyroid Stimulating Hormone (TSH) <input type="checkbox"/> Androcorticotrophic Hormone	Additional Details:
	Which hormones are being supplemented?	Additional Details:
<b>Please attach chart notes with lab levels. These items are required for review of this request.</b>		
<input type="checkbox"/>	<b>Prader-Willi Syndrome</b>	
Additional Question(s)	Has the diagnosis of Prader-Willi Syndrome been confirmed by appropriate genetic testing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
	<b>Please attach growth curve charts and include all lab levels. These items are required for review of this request.</b>	
<input type="checkbox"/>	<b>Noonan Syndrome</b>	
Additional Question(s)	Has the diagnosis of Noonan's syndrome been established by genetic testing or in consultation with a geneticist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
	<b>Please attach growth curve charts and include all lab levels. These items are required for review of this request.</b>	
<input type="checkbox"/>	<b>Other Diagnosis (please specify below)</b>	
Additional Question(s)	<b>What is the patient's diagnosis? (Check all that apply)</b> <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Idiopathic Short Stature of Unknown Origin <input type="checkbox"/> Intrauterine Growth Restriction (IUGR) <input type="checkbox"/> Juvenile Rheumatoid Arthritis <input type="checkbox"/> Non-Growth Hormone Deficient Short Stature <input type="checkbox"/> Osteogenesis imperfecta <input type="checkbox"/> Precocious puberty <input type="checkbox"/> Russell-Silver Syndrome <input type="checkbox"/> Skeletal dysplasia, such as achondroplasia <input type="checkbox"/> Other (please specify):	Additional Details:
	<b>Questions for Adult Patients</b>	
<input type="checkbox"/>	<b>Adult Growth Hormone Deficiency</b>	
Additional Question(s)	Has this patient been evaluated by an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
	Is this patient's growth hormone deficiency a result of documented <b>childhood</b> growth hormone deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
	Is this patient's growth hormone deficiency a result of any of the following conditions? (Mark all that apply) <input type="checkbox"/> Destructive hypothalamic disease <input type="checkbox"/> Destructive pituitary disease <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Surgery (please provide details about the procedure) <input type="checkbox"/> Trauma (please provide details about the nature of trauma)	Additional Details:
	Has this patient had a growth hormone response of less than 5ng/mL to at least ONE provocative stimulus? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:

	Which provocative stimuli tests were performed? Please specify the date and lab value of tests performed.			Additional Details:	
	<input type="checkbox"/>	<b>Stimuli</b>	<b>Lab Value</b>		<b>Date Taken</b>
	<input type="checkbox"/>	Insulin			
	<input type="checkbox"/>	Levodopa			
	<input type="checkbox"/>	L-Arginine			
	<input type="checkbox"/>	Clonidine			
	<input type="checkbox"/>	Glucagon			
<input type="checkbox"/>	Arginine-GHRH				
Have other pituitary hormone deficiencies (thyroid, cortisol and sex hormones) been ruled out or corrected? <input type="checkbox"/> Yes <input type="checkbox"/> No			Additional Details:		

**Please attach chart notes with lab values. These items are required for review of this request.**

Additional Question(s)	<b>Multiple Pituitary Hormone Deficiencies / Panhypopituitarism</b>			Additional Details:
	Has this patient been evaluated by an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Which of the following anterior pituitary hormones are absent in this patient? Please mark all that apply. <input type="checkbox"/> Luteinizing Hormone (LH) <input type="checkbox"/> Follicle Stimulating Hormone (FSH) <input type="checkbox"/> Thyroid Stimulating Hormone (TSH) <input type="checkbox"/> Androcorticotrophic Hormone			

**Please attach chart notes with lab values and details of hormonal replacement therapy. These items are required for review of this request.**

**AIDS Wasting (Serostim Only)**

Additional Question(s)	What was the patient's <b>pre-treatment baseline body weight</b> ?	Answer/Detail:
	What is the patient's <b>current body weight</b> ?	Additional Details:
	What is the patient's <b>current body mass index</b> ?	Additional Details:
	Has this patient had failure to treatment with, or contraindication or intolerance to appetite stimulants and/or other anabolic agents? (Please provide medication details in the Additional Details section.) <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
	Will this patient have continuous use of antiviral therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:

**Please attach chart notes with lab values. These items are required for review of this request.**

**Short Bowel Syndrome (Zorbitive Only)**

Additional Question(s)	Will this medication be used with a special diet AND glutamine supplementation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:
	Is this patient dependant on intravenous parenteral nutrition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional Details:

**Please attach chart notes supporting this request. These items are required for review of this request.**

**Other Diagnosis (please specify below)**

Additional Question(s)	<b>What is the patient's diagnosis? (Check all that apply)</b> <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Increased Athletic Performance <input type="checkbox"/> Infertility <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Somatopause <input type="checkbox"/> Other (please specify):	Additional Details:

**\*\*PLEASE ATTACH GROWTH CHART AND PROGRESS NOTES\*\***

BOARD CERTIFIED ENDOCRINOLOGIST'S NAME:

PHYSICIAN'S PRINTED NAME:

DATE:

PHYSICIAN'S SIGNATURE: (Physician's signature indicates accuracy and completeness of prescription information)

In order for a brand name product to be dispensed, the prescriber must handwrite "**Brand Necessary**" or "**Brand Medically Necessary**" on the prescription

- It is the decision of the prescribing physician in the exercise of his/her independent clinical judgment to determine which medication to prescribe. Coverage is not limited to the preferred drug.
- CIGNA HealthCare may receive payments from manufacturers whose medications are included on the Preferred Specialty (Injectable) Drug List. These payments may or may not be shared with the member's benefit plan dependent on the contractual arrangement between the plan and CIGNA.
- Depending upon plan design, market conditions, the extent to which manufacturers' payments are shared with the member's benefit plan, and other factors as of the date of service, the preferred medication may or may not represent the lowest cost medication within the therapeutic class for the member and/or the benefit plan.
- CIGNA HealthCare reserves the right to make changes to its Preferred Specialty (Injectable) Drug List without notice.

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