EXPRESS SCRIPTS®

Clear Print

Prior Authorization Request

GENOTROPIN, HUMATROPE, NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN, OMNITROPE, SAIZEN (somatropin)

Instructions

Please complete Part A and have your physician complete Part B. Completion and submission is not a guarantee of approval. Any fees related to the completion of this form are the responsibility of the plan member. Drugs in the Prior Authorization Program may be eligible for reimbursement if the patient does not qualify for coverage under a primary plan or a government program. Drugs used for indications not approved by Health Canada may be denied. For Quebec plan members, RAMQ exception drug criteria may apply. The decision for approval versus denial is based on pre-defined clinical criteria, primarily based on Health Canada approved indication(s) and on supporting evidence-based clinical protocols. The plan member will be notified whether their request has been approved or denied. Please note that you have the right to appeal the decision made by Express Scripts Canada.

Part A – Patient

Patient information

First Name:	Last Name:	
Insurance Carrier Name/Number:		
Group Number:	Client ID:	
Date of Birth (YYYY/MM/DD):	Relationship: ☐ Employee ☐ Spouse ☐ Dependent	
Language: ☐ English ☐ French	Gender: ☐ Male ☐ Female	
Address:		
City:	Province:	Postal Code:
Email address:		
Telephone (home):	Telephone (cell):	Telephone (work):

Coordination of benefits

Patient Assistance Program	Is the patient enrolled in any patient assistance program? ☐ Yes ☐ No Contact Name: _____ Telephone: _____
Provincial Coverage	Has the patient applied for reimbursement under a provincial plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****
Primary Coverage	Has the patient applied for reimbursement under a primary plan? ☐ Yes ☐ No ☐ N/A What is the coverage decision of the drug? ☐ Approved ☐ Denied ***Attach decision letter****

Authorization

On behalf of myself and my eligible dependents, I authorize my group benefit provider, and its agents, to exchange the personal information contained on this form. I give my consent on the understanding that the information will be used solely for purposes of administration and management of my group benefit plan. This consent shall continue so long as my dependents and I are covered by, or are claiming benefits under the present group contract, or any modification, renewal, or reinstatement thereof.

_____ _____

Plan Member Signature Date

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Part B – Prescriber

Please see instructions on page 1 and complete all sections below. Incomplete forms may result in automatic denial. Please do **not** provide genetic test information or results.

SECTION 1 – DRUG REQUESTED

☐ GENOTROPIN ☐ HUMATROPE	☐ NORDITROPIN NORDIFLEX ☐ NUTROPIN AQ NUSPIN	☐ OMNITROPE ☐ SAIZEN	☐ New request ☐ Renewal request*
Dose	Administration (ex: oral, IV, etc)	Frequency	Duration

Site of drug administration:

☐ Home ☐ Physician's office/Infusion clinic ☐ Hospital (outpatient) ☐ Hospital (inpatient)

* Please submit proof of prior coverage if available

SECTION 2 – ELIGIBILITY CRITERIA

1. **Please indicate if the patient satisfies the below criteria:**

Growth Hormone Deficiency in Children

- ☐ For the treatment of children who have growth failure due to an inadequate secretion of endogenous growth hormone (growth hormone deficiency (GHD)), AND
- ☐ The patient's epiphyses are not closed

Growth Hormone Deficiency in Adults – *Not a Health Canada approved indication for NORDITROPIN NORDIFLEX*

- ☐ For the treatment of an adult with childhood onset growth hormone deficiency (GHD) as a result of congenital, genetic, acquired, or idiopathic causes, OR
- ☐ For the treatment of an adult with adult onset growth hormone deficiency (GHD) alone or associated with multiple hormone deficiencies (hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma

Turner Syndrome

- ☐ For the treatment of children with Turner syndrome, AND
- ☐ The patient's epiphyses are not closed

Idiopathic Short Stature – *Not a Health Canada approved indication for NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN, or SAIZEN*

- ☐ For the treatment of idiopathic short stature (ISS), or non-growth hormone-deficient short stature in children, AND
- ☐ The patient's height is at least 2.25 standard deviation scores (SDS) below the mean (-2.25) for age and sex, AND
- ☐ The patient's epiphyses are not closed

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Small for Gestational Age – *Not a Health Canada approved indication for NUTROPIN AQ NUSPIN*

- ☐ For the treatment of growth failure in children born small for gestational age, AND
- ☐ The patient's current height standard deviation score (SDS) is less than -2, AND
- ☐ The patient's birth weight and/or length is at least 2 standard deviations (SD) below the mean (-2), AND
- ☐ The patient was unable to achieve catch-up growth by 2 years of age, AND
- ☐ The patient has a height velocity standard deviation score of less than 0 during the last year, AND
- ☐ The patient's epiphyses are not closed

Prader-Willi Syndrome – *Not a Health Canada approved indication for HUMATROPE, NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN, OMNITROPE, or SAIZEN*

- ☐ For the treatment of growth failure in children due to Prader-Willi syndrome (PWS), or improvement of body composition in children with PWS, AND
- ☐ The patient's epiphyses are not closed

Short Stature Homeobox-containing Gene (SHOX) Deficiency – *Not a Health Canada approved indication for GENOTROPIN, NORDITROPIN NORDIFLEX, NUTROPIN AQ NUSPIN, OMNITROPE, or SAIZEN*

- ☐ For the treatment of short stature or growth failure in children with SHOX (short stature homeobox-containing gene) deficiency, AND
- ☐ The patient's epiphyses are not closed

Noonan Syndrome – *Not an approved indication for GENOTROPIN, HUMATROPE, NUTROPIN AQ NUSPIN, OMNITROPE, or SAIZEN*

- ☐ For the treatment of children with short stature associated with Noonan syndrome, AND
- ☐ The patient is 3 years of age or older and prepubertal, AND
- ☐ The patient's height standard deviation score (SDS) is -2 or below, AND
- ☐ The patient's epiphyses are not closed

OR

- ☐ None of the above criteria applies.

Relevant additional information:

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2. Please list previously tried therapies

Drug	Dosage and administration	Duration of therapy		Reason for cessation	
		From	To	Inadequate response	Allergy/ Intolerance
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

SECTION 3 – PRESCRIBER INFORMATION

Physician's Name:	
Address:	
Tel:	Fax:
License No.:	Specialty:
Physician Signature:	Date:

Please fax or mail the completed form to Express Scripts Canada®

Fax:
Express Scripts Canada Clinical Services
1 (855) 712-6329

Mail:
Express Scripts Canada Clinical Services
5770 Hurontario Street, 10th Floor
Mississauga, ON L5R 3G5