



Arkansas Blue Cross Blue Shield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare) Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS) Zorbtive (Medicare Determination)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Zorbtive (Medicare Determination).

Drug Name (select from list of drugs shown)
Zorbtive (somatropin)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|-------|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Does the patient have the diagnosis of Short Bowel Syndrome, defined as 50-100 cm residual small bowel? | Y | N |
| 3. Is the patient currently receiving and will the patient continue to receive any one or a combination of the following specialized nutritional support?
- high complex-carbohydrate, low-fat diet
- TPN, IPN, PPN
- rehydration solutions
- electrolyte replacement | Y | N |
| 4. Does the patient have recently diagnosed or recurrent active neoplasia? | Y | N |
| 5. Has the patient received four weeks of Zorbtive therapy?
[If the answer to this question is yes, then may skip to question 7.] | Y | N |
| 6. How many weeks of therapy has the patient received?
[No further questions required.] | | _____ |



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|---|---|---|
| 7. Is the patient continuing to lose weight? | Y | N |
| 8. Have the requirements of the patient for specialized nutritional support significantly decreased as measured by total volume, total calories, and frequency of infusion? | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date