

# Pharmacy Medical Necessity Form

Last Reviewed: Sept. 2011

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

**Zorbtive<sup>®</sup> (somatropin-rDNA origin)**  Urgent  Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

**Product:**

Zorbtive Injection 8.8 mg

Dose: \_\_\_\_\_ Start date: \_\_\_\_\_

**Priority Health precertification requirement:**

**Authorization of Zorbtive requires:**

- Diagnosis of short bowel syndrome
- Must be receiving total parenteral nutrition (TPN)
- Must be participating in a program that manages dietary intake and hydration

**Please Complete the Following Information:**

Diagnosis:

Short Bowel Syndrome

Other: \_\_\_\_\_ Please provide rationale for use:

\_\_\_\_\_

Patient is receiving total parenteral nutrition (TPN):

Yes

No – Rationale for use: \_\_\_\_\_

Patient is involved in a program that manages dietary intake and hydration:

Yes

No – Rationale for use: \_\_\_\_\_

**Other Information:**

- Product is recombinant human growth hormone

**For Medicare only:** If none of the above is applicable to this member, please check which, if any, of the following apply:

All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects

The number of doses available under a dose restriction for the prescription drug:

Has been ineffective in the treatment of the enrollee's disease or medical condition or,

Based on both sound clinical evidence and medical and scientific evidence, the known

relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance

- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
- None of the above apply

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\***  
**Please fax this request to: (877)974-4411 toll free or (616)942-8206**  
**YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**