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Growth Hormone Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7.
Diagnosis:
_____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied; Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). If the criteria for coverage are met, initial requests will be given for 12-months, unless otherwise stated in criteria. Additional prior authorizations will be considered upon

documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.

Preferred	**Non- Preferred**	
□ Norditropin	□ Genotropin	□ Saizen
□ Nutropin AQ Pen	□ Humatrope	□ Tev-Tropin
□ Nutropin AQ NuSpin	□ Omnitrope	□ Zorbtive

Number of vials per month: _____ Estimate length of therapy: _____

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges): _____

_____

_____

Reason for use of Non-Preferred drug requiring prior approval: _____

_____

□ **Children with Growth Hormone Deficiency**

1. Standard deviation of 2.0 or more below mean height for chronological age; and
2. No expanding intracranial lesion or tumor diagnosed by MRI; and
3. Growth rate below five centimeters per year; and
4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and
5. Annual bone age testing is required. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
6. Epiphyses open.

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____

Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No

MRI diagnosis: _____ Date:_____

Growth rate per year _____

Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far: _____

_____

Please provide 2 stimuli tests and results:

_____

_____

□ **Pediatric Chronic Kidney Disease**

1.Is prescribed by or in consultation with a nephrologist; and
2.Standard deviation of 2.0 or more below mean height for chronological age; and
3. No expanding intracranial lesion or tumor diagnosed by MRI; and
4. Growth rate below five centimeters per year; and
5. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
6. Epiphyses open.

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No
Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____
Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No
MRI diagnosis: _____ Date:_____
Growth rate per year _____
Is prescriber a nephrologist? □ Yes □ No If no, note consultation with nephrologist:
Consultation date: _____ Physician name & phone: _____

□ **Turner's Syndrome**

1.Chromosomal abnormality showing Turner's syndrome; and
2. Prescribed by or in consultation with an endocrinologist; and
3. Standard deviation of 2.0 or more below mean height for chronological age; and
4. No expanding intracranial lesion or tumor diagnosed by MRI; and
5. Growth rate below five centimeters per year; and
6. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
7. Epiphyses open.

Chromosomal abnormality showing Turner's syndrome? Yes (attach results) No
Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No
Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____
Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No
MRI diagnosis: _____ Date:_____
Growth rate per year _____
Is prescriber an endocrinologist? Yes No If no, note consultation with endocrinologist:
Consultation date: _____ Physician name & phone: _____

□ **Prader Willi Syndrome**

1.Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
4. Epiphyses open.

Diagnosis confirmed by genetic testing? Yes (attach results) No
Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No
Is prescriber an endocrinologist? ❑Yes ❑No If no, note consultation with endocrinologist:
Consultation date: _____ Physician name & phone: _____

□ **Noonan Syndrome**

1.Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. Standard deviation of 2.0 or more below mean height for chronological age; and
4. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and

5. Epiphyses open.

Diagnosis confirmed by genetic testing? Yes (attach results) No

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Is prescriber an endocrinologist? ❑ Yes ❑ No If no, note consultation with endocrinologist:

Consultation date: _____ Physician name & phone: _____

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____

Is standard deviation 2.0 or more below mean height for chronological age? ❑ Yes ❑ No

□ **SHOX (Short Stature Homeobox)**

1.Diagnosis is confirmed by appropriate genetic testing (attach results); and

2. Prescribed by or in consultation with an endocrinologist; and

3. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and

4. Epiphyses open.

Diagnosis confirmed by genetic testing? ❑ Yes (attach results) ❑ No

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Is prescriber an endocrinologist? ❑ Yes ❑ No If no, note consultation with endocrinologist:

Consultation date: _____ Physician name & phone: _____

□ **Adults with Growth Hormone Deficiency**

1. Patients who were growth hormone deficient during childhood (childhood onset) and who have continued deficiency; or

2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g. panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and

3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of ≤ 5 mcg/L after stimulation.

- o Childhood Onset
- o Adult Onset: provide pituitary or hypothalamic disease diagnosis: _____

Please provide stimuli test, date and result: _____

□ **Adults with AIDS Wasting/Cachexia**

1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and

2. Patient is currently being treated with antiviral agents; and

3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol).

Has patient experienced > 10% weight loss over 12 months?

❑ Yes Baseline weight & date:_____ Current weight & date: _____ ❑ No

Does patient have concurrent illness other than HIV infection contributing to weight loss? ❑ Yes ❑ No

Current antiviral treatment: Drug name, dosing & trial dates: _____

_____

Appetite stimulant trial:

Drug Name and Dose: _____ Trial dates: _____

Failure reason: _____

□ **Short Bowel Syndrome**

If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel syndrome. PA will be considered for a maximum of 4 weeks.

Provide nutritional support plan: _____

_____

□ **Renewals (in addition to above criteria)**

Clinical response to therapy: _____

_____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.