Growth Hormone Medications Prior Authorization Request Form

Phone: (800) 303-9626
Fax: (844) 807-8455

NOTE: Please ensure completion of this form in its entirety and attach required *documentation* for an accurate review.

Please indicate: ☐ Request initiated for: _____

Start of treatment: Start date ____/____/_____

☐Continuation of therapy: Name & Date of last treatment _____ ***Provide documentation***

Approving health plan/ pharmacy benefit manager: _____ ***Attach approval letter***

PATIENT INFORMATION

Full Name: _____
ID: _____
DOB: _____
Phone: _____
Allergies: _____

PRESCRIBER INFORMATION

Full Name: _____ NPI #:_____
Specialty: _____
Office Phone: _____
Office Fax: _____
Office Address: _____

SPECIALIST INFORMATION

Is the growth hormone therapy being prescribed by or in consultation with one of the following specialists?

☐ Pediatric endocrinologist ☐ Endocrinologist ☐ Geneticist ☐ Pediatric nephrologist ☐ Gastroenterologist
☐ Nutritional support specialist ☐ Other: _____

Specialist's Name: _____ Specialist's Office Phone: _____

PRODUCT INFORMATION

Request is for: ☐ Norditropin ***preferred*** ☐ Humatrope ☐ Genotropin ☐ Nutropin AQ
☐ Omnitrope ☐ Saizen ☐ Zomacton ☐Other: _____

Dose: _____ Frequency: _____

If NON-Preferred Product is chosen:

☐ Documented intolerable adverse effect to Norditropin ***Provide documentation***
☐ Documented contraindication to or any of Norditropin's components ***Provide documentation***
☐ None of the above, Explain. _____

DIAGNOSIS INFORMATION

What is the diagnosis?

☐ Pediatric GHD*
☐ Turner Syndrome (TS)
☐ Noonan Syndrome (NS)
☐ Small for gestational age (SGA)
☐ Idiopathic short stature (ISS)

☐ Growth failure associated with:
☐ Cerebral palsy (CP)
☐ Cystic fibrosis (CF)
☐ Chronic kidney disease (CKD)
☐ Russell-Silver syndrome (RSS)
☐ Congenital adrenal hyperplasia (CAH)

☐ Adult GHD*
☐ HIV-associated wasting/cachexia
☐ Prader-Willi syndrome (PWS)
☐ Short-bowel syndrome (SBS)
☐ SHOX Deficiency (SHOXD)

☐ Other: _____
☐ ICD-10 Code: _____

*Includes panhypopituitarism

CLINICAL INFORMATION

Please provide the following **pretreatment** values:

Current Age: _____ years _____ months Current Height (cm): _____ Current Weight (kg): _____ *Date:* _____
Growth velocity (GV): _____ cm/year Prior Year Height (cm): _____ Prior Year Weight (kg): _____ *Date:* _____
Epiphyses: ☐ Open ☐ Closed ***MUST Attach X-Ray results that confirm status, especially for pediatrics***

Complete the following based on patient's diagnosis, if applicable.

Short Bowel Syndrome (SBS):

1. Will somatropin be used in conjunction with optimal management of SBS? ☐ Yes ☐ No
2. How many weeks of GH therapy has the patient received in their lifetime? _____ weeks

SHOX Deficiency (SHOXD):

1. Has the diagnosis of SHOX deficiency been confirmed by molecular/ genetic analysis? ☐ Yes ☐ No

If YES, ATTACH molecular/genetic test results

CLINICAL INFORMATION (continued)

Turner Syndrome (TS):

1. Has the diagnosis of Turner syndrome been confirmed by karyotyping? ☐ Yes ☐ No ***If YES, ATTACH karyotype study results***

Small for Gestational Age (SGA):

1. What was the patient's gestational age at birth? _____ weeks _____ days
2. What was the patient's: Birth Weight? _____ grams AND Birth Height _____ cm
3. Did the patient fail to manifest catch-up growth by age two as demonstrated by **pretreatment** height greater than 2 SD below the mean for age and gender? ☐ Yes ☐ No ***If YES, ATTACH growth chart from age TWO***

Prader-Willi Syndrome (PWS):

1. Has the diagnosis of Prader-Willi syndrome been confirmed by genetic testing demonstrating any of the following?

☐ Deletion in the chromosomal 15q11.2-q13 region
☐ Imprinting defects or translocations involving chromosome 15
☐ Maternal, uniparental disomy in chromosome 15
☐ None of the above

If ANY of the above, ATTACH genetic test results

2. *If currently on therapy*, have bodily composition and psychomotor function improved or stabilized in response to GH therapy?
☐ Yes ☐ No ☐ N/A, not currently on therapy

Idiopathic Short Stature Syndrome:

1. What is the patient's **pretreatment** predicted adult height? _____feet _____ cm
2. Has the patient failed to respond to at least two standard GH stimulation tests? ☐ Yes ☐ No

☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____
☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____

ATTACH laboratory report or medical record of pre-treatment provocative test results

HIV-Related Wasting/ Cachexia:

1. Is the patient on anti-retroviral therapy? ☐ Yes ☐ No
2. Provide the following:

Pretreatment Height: _____ cm Weight: _____ kg BMI: _____kg/m^2 Date taken: _____
Current Height: _____ cm Weight: _____ kg BMI: _____kg/m^2 Date taken: _____

3. *If new to GH therapy*, has the patient tried and had a suboptimal response to alternative therapies (ie, dronabinol, megesterol, cyproheptadine, or testosterone if hypogonadal)?
☐ Yes ☐ No ☐ N/A, patient is currently on GH therapy
4. Did the patient have a contraindication or intolerance to alternative therapies? ☐ Yes ☐ No

If YES, ATTACH documentation for each applicable question

Adult GHD (includes panhypopituitarism):

1. Has the patient had any **pretreatment** pharmacologic provocative tests or a pretreatment test with the agent Macrilen?
☐ Yes, *How many* ____ ☐ No

If YES, ATTACH laboratory report or medical record of pre-treatment provocative test results

☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____
☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____
☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____

2. Does the patient have a low **pretreatment** IGF-1 level for age and gender? ☐ Yes ☐ No

If YES, ATTACH laboratory report or medical record of pretreatment IGF-1 level

Indicate patient's pretreatment IGF-1 level: _____ Range: _____

3. Does the patient have a structural abnormality of the hypothalamus or pituitary gland? ☐ Yes ☐ No, *If no skip to #5*
4. Does the patient have deficiencies of greater than or equal to 3 pituitary hormones? ☐ Yes ☐ No

If yes, indicate below, provide medical records and no further questions or mark "No deficiencies of pituitary hormones"

☐ Growth hormone ☐ Adrenocorticotropic hormone (ACTH) ☐ Antidiuretic hormone (ADH)
☐ Luteinizing hormone (LH) ☐ Follicle stimulating hormone (FSH) ☐ Thyroid stimulating hormone (TSH)
☐ Prolactin ☐ Other: _____ ☐ No deficiencies of pituitary, *continue to #5*

5. Did the patient have childhood-onset GHD? ☐ Yes ☐ No ***If YES, ATTACH medical records for question(s) 5 & 6***
6. Does the patient have congenital abnormality of the hypothalamus or pituitary gland? ☐ Yes ☐ No

CLINICAL INFORMATION (continued)

Pediatric Disorders (includes Pediatric GHD):

1. Indicate patient's **pretreatment** height and age (***two measurements at least 6 months apart)***

a) Height: _____ cm Age: _____ years _____ months Date: _____

b) Height: _____ cm Age: _____ years _____ months Date: _____

2. Has patient had any **pretreatment** pharmacologic provocative tests? ☐Yes, *How many* ____ ☐No

If YES, ATTACH laboratory report or medical record of pre-treatment provocative test results

☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____

☐ Agent: _____ Serum GH peak level (ng/ml): _____ Date test taken: _____

3. *If currently on therapy*, is the patient growing more than 2cm/year? ☐Yes ☐No ***If YES, attach medical records***

If No, indicate clinical reason for the lack of efficacy: _____

Indicate therapy start date: _____

Pediatric GHD (includes panhypopituitarism):

1. Is the patient a neonate or was the patient diagnosed as with GH deficiency as a neonate?☐ Yes ☐ No *If No, skip to #3*
2. Are medical records available to support diagnosis of neonatal GH deficiency such as hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiencies, MRI results, or chart notes? ☐Yes ☐No ***If YES, attach medical records***
3. Does the patient have a pituitary or CNS disorder?

☐ Known mutation in GH-releasing hormone receptor, GH gene, GH receptor, or pituitary transcription factors

☐ CNS tumor/ neoplasm (ie, craniopharyngioma, glioma, pituitary adenoma)

☐ Optic nerve hypoplasia/ septo-optic dysplasia	☐ Empty sella syndrome	☐ Ectopic posterior pituitary
☐ Pituitary aplasia/ hypoplasia	☐ Agenesis of corpus callosum	☐ Surgery
☐ Cyst (Rathke cleft cyst or arachnoid cleft cyst)	☐ Chemotherapy	☐ Pituitary stalk defect
☐ Anencephaly or prosencephaly	☐ Radiation	☐ Other mid-line defect
☐ Vascular malformation	☐ CNS infection	
☐ Head trauma/ traumatic brain injury	☐ Aneurysmal subarachnoid hemorrhage	
☐ CNS infarction (ie, Sheehan's syndrome)	☐ Inflammatory lesion (ie, autoimmune hypophysitis)	
☐ Infiltrative lesion (ie, sarcoidosis)		
☐ No pituitary or CNS disorder	☐ Other: _____	

If ANY, ATTACH medical records

4. Does the patient have a **pretreatment** IGF-1 level greater than 2 SD below the mean? ☐ Yes ☐ No

If YES, attach laboratory report or medical record of pretreatment IGF-1 level

Indicate patient's pretreatment IGF-1 level: _____ Range: _____

Please attach the most recent clinical notes or supporting documentation

I attest that this information is accurate and true, and that documentation supporting this information was attached and is available for review if requested by MetroPlus Health Plan or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy/)**

Please complete the following contact information in case additional information is needed.

Office Contact Person: _____ Contact Phone: _____ Ext #: _____

Date Form Completed and Faxed: _____

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