

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis (ICD code plus description):	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For All Requests:

1. What is the patient’s weight? _____ (kg)
2. Is the patient currently treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** Yes No
3. Is the patient a child or adult? Please select one: Child Adult
4. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify contraindication(s): _____

5. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
6. Is the patient’s age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, is there support for using the requested agent for the patient's age for the requested indication? Yes No
 If yes, please provide supporting information: _____

7. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____

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For Short Acting Agents:

8. Please answer the following questions and **submit chart notes or medical records to support the answers**. The preferred agents are: Genotropin, Genotropin MiniQuick, and Omnitrope. Please note, chart notes are required.

- Has the patient tried and had an inadequate response to ONE preferred short-acting agent? Yes No
- Was ONE preferred short-acting agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does the patient have an intolerance or hypersensitivity to ONE preferred short-acting agent that is not expected to occur with the requested agent? Yes No
- Does the patient have an FDA labeled contraindication to ALL preferred short-acting agent(s) that is not expected to occur with the requested agent? Yes No
- Is ONE preferred short-acting agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
- Is ONE preferred short-acting agent not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a preferred short-acting agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Are there medical records showing support for the efficacy of the requested agent over ALL preferred short-acting GH agent(s) for the requested indication? Yes No

For Long Acting Agents:

9. Is the requested agent a preferred long-acting GH agent? The preferred agent is: Skytrofa..... Yes No
 If no, is the preferred long-acting GH agent FDA labeled for the requested indication? The preferred agent is: Skytrofa. Yes No

If yes, has the patient received at least 12 months of therapy with a preferred long-acting agent? The preferred agent is: Skytrofa. Yes No

If yes, please specify duration: _____

If no, please answer the following questions and **submit chart notes or medical records to support the answers**. The preferred agent is: Skytrofa.

- Has the patient tried and had an inadequate response to a preferred long-acting GH agent? Yes No
- Was a preferred long-acting GH agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
- Does the patient have an intolerance or hypersensitivity to ONE preferred long-acting agent that is not expected to occur with the requested agent? Yes No
- Does the patient have an FDA labeled contraindication to ALL preferred long-acting GH agent(s) that is NOT expected to occur with the requested agent? Yes No
- Is a preferred long-acting GH agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
- Is a preferred long-acting GH agent not in the best interest of the patient based on medical necessity? Yes No
- Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a preferred long-acting GH agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

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10. Has the patient received at least 12 months of therapy with a preferred short-acting GH agent? The preferred agents are: Genotropin, Genotropin MiniQuick, and Omnitrope. Yes No
- If yes, please specify agent(s) and duration: _____
- If no, please answer the following questions and **submit chart notes or medical records to support the answers.** The preferred agents are: Genotropin, Genotropin MiniQuick, and Omnitrope.
- Has the patient tried and had an inadequate response to ONE preferred short-acting agent? Yes No
 - Was ONE preferred short-acting agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No
 - Does the patient have an intolerance or hypersensitivity to ONE preferred short-acting agent that is not expected to occur with the requested agent?..... Yes No
 - Does the patient have an FDA labeled contraindication to ALL preferred short-acting agents that is NOT expected to occur with the requested agent? Yes No
 - Is ONE preferred short-acting agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
 - Is ONE preferred short-acting agent not in the best interest of the patient based on medical necessity?..... Yes No
 - Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a preferred short-acting agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?..... Yes No

For Children: Short-Acting Growth Hormone Requests:

11. Does the patient have hypoglycemia?..... Yes No
12. Does the patient have a serum growth hormone (GH) concentration less than or equal to 5 mcg/L? **Please note, chart notes are required.**..... Yes No
- If yes, does the patient have congenital pituitary abnormality (e.g., ectopic posterior pituitary and pituitary hypoplasia with abnormal stalk)?..... Yes No
- If no, does the patient have deficiency of at least one additional pituitary hormone? Yes No
- If no, does the patient have a growth hormone (GH) concentration less than 20 mcg/L? **Please note, chart notes are required.**..... Yes No
- If yes, does the patient have a known metabolic disorder?..... Yes No
- If no, does the patient have a reduced IGFBP-3 level (e.g., less than -2 SD)?..... Yes No
13. Please select the patients' diagnosis and answer the corresponding questions. **Please note, chart notes are required.**
- Chronic renal insufficiency
- Is the patient's height velocity (HV) for age less than -1.88 SD OR HV for age is less than the 3rd percentile? **Please note, chart notes are required.**..... Yes No
 - Have other etiologies for growth impairment been addressed? Yes No
- Growth hormone deficiency (GHD) or growth failure due to inadequate secretion of endogenous growth hormone
- Does the patient have extreme short stature (e.g., height less than or equal to -3 SD), normal nutrition, significantly reduced insulin-like growth factor-1 (IGF-1) and IGFBP-3 (e.g., less than -2 SD), and delayed bone age? **Please note, chart notes are required.**..... Yes No
 - Does the patient have ONE of the following? **Please note, chart notes are required.**
 - Height greater than 2 SD below the mean for age and sex
 - Height greater than 1.5 SD below the mid-parental height
 - A decrease in height SD of greater than 0.5 SD over one year in children greater than 2 years of age
 - Height velocity (HV) greater than 2 SD below the mean over one year or greater than 1.5 SD sustained over two years
 - Height-for-age curve that has deviated downward across two major height percentile curves (e.g., from above the 25th percentile to below the 10th percentile)
 - The patient's age is 2-4 years AND the patient has a HV less than 5.5 cm/year (less than 2.2 inches/year)

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- The patient's age is 4-6 years AND the patient has a HV less than 5 cm/year (less than 2 inches/year)
- The patient's age is 6 years to puberty AND the patient's sex is male and HV is less than 4 cm/year (less than 1.6 inches/year)
- The patient's age is 6 years to puberty AND the patient's sex is female and HV is less than 4.5 cm/year (less than 1.8 inches/year)
- None of the above

- Has the patient failed at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab)? **Please note, chart notes are required.** Yes No

If no, has the patient failed at least ONE GH stimulation test (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab)? **Please note, chart notes are required.**..... Yes No

If yes, does the patient have ONE of the following? **Please note, chart notes are required.**

- Pathology of the central nervous system
- History of irradiation
- Other pituitary hormone defects (e.g., multiple pituitary hormone deficiency [MPHD])
- A genetic defect
- none of the above

Does the patient have a pituitary abnormality and a known deficit of at least one other pituitary hormone? **Please note, chart notes are required.** Yes No

If no, does the patient have a pituitary abnormality and a known deficit of at least one other pituitary hormone? **Please note, chart notes are required.**..... Yes No

Idiopathic short stature (ISS)

- Does the patient have a height less than or equal to -2.25 SD below the corresponding mean height for age and sex? **Please note, chart notes are required.**..... Yes No
- Does the patient have open epiphyses? Yes No
- Has the patient been evaluated for constitutional delay of growth and puberty (CDGP)? Yes No
- If yes, does the patient have a diagnosis of CDGP? Yes No
- Does the patient have ONE of the following? **Please note, chart notes are required.**
 - Patient's sex is male and predicted adult height is less than 63 inches
 - Patient's sex is female and predicted adult height is less than 59 inches
 - Patient is greater than 2 SD below their mid-parental target height
 - None of the above

Noonan syndrome

Panhypopituitarism or deficiencies in at least THREE or more pituitary axes

- Does the patient have a serum insulin-like growth factor-1 (IGF-1) level below the age- and sex-appropriate reference range when off GH therapy? **Please note, chart notes are required.** Yes No

Prader-Willi syndrome

Short bowel syndrome (SBS)

- Is the patient receiving specialized nutritional support? **Please note, chart notes are required.**..... Yes No

SHOX gene deficiency

Small for gestational age (SGA)

- Does the patient have a documented birth weight and/or birth length that is greater than or equal to 2 SD below the mean for gestational age? **Please note, chart notes are required.** Yes No
- At 24 months of age, did the patient fail to manifest catch-up growth evidenced by a height that remains 2 or more standard deviations (SD) below the mean for age and sex? Yes No

Turner syndrome

Other (Please specify) _____

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For Children: Long-Acting Growth Hormone Requests:

14. Please select the patients' diagnosis and answer the corresponding questions. **Please note, chart notes are required.**

- Growth hormone deficiency (GHD) or growth failure due to inadequate secretion of endogenous growth hormone
 - Does the patient have extreme short stature (e.g., height less than or equal to -3 SD), normal nutrition, significantly reduced insulin-like growth factor-1 (IGF-1) and IGFBP-3 (e.g., less than -2 SD), and delayed bone age? **Please note, chart notes are required.**..... Yes No
 - Does the patient have ONE of the following? **Please note, chart notes are required.**
 - Height greater than 2 SD below the mean for age and sex
 - Height greater than 1.5 SD below the mid-parental height
 - A decrease in height SD of greater than 0.5 SD over one year in children greater than 2 years of age
 - Height velocity (HV) greater than 2 SD below the mean over one year or greater than 1.5 SD sustained over two years
 - Height-for-age curve that has deviated downward across two major height percentile curves (e.g., from above the 25th percentile to below the 10th percentile)
 - The patient's age is 2-4 years AND the patient has a HV less than 5.5 cm/year (less than 2.2 inches/year)
 - The patient's age is 4-6 years AND the patient has a HV less than 5 cm/year (less than 2 inches/year)
 - The patient's age is 6 years to puberty AND the patient's sex is male and HV is less than 4 cm/year (less than 1.6 inches/year)
 - The patient's age is 6 years to puberty AND the patient's sex is female and HV is less than 4.5 cm/year (less than 1.8 inches/year)
 - None of the above
 - Has the patient failed at least 2 GH stimulation tests (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab)?..... Yes No
 If no, has the patient failed at least ONE GH stimulation test (e.g., peak GH value of less than 10 mcg/L after stimulation, or otherwise considered abnormal as determined by testing lab)?..... Yes No
 If yes, does the patient have any of the following? Select all that apply.
 - Pathology of the central nervous system
 - History of irradiation
 - Other pituitary hormone defects (e.g., multiple pituitary hormone deficiency [MPHD])
 - A genetic defect
 - none of the above
 Does the patient have a pituitary abnormality and a known deficit of at least one other pituitary hormone? Yes No
 If no, does the patient have a pituitary abnormality and a known deficit of at least one other pituitary hormone? Yes No
- Other (Please specify) _____

For Adult Requests:

15. Please select the patients' diagnosis and answer the corresponding questions. **Please note, chart notes are required.**

- AIDS wasting/cachexia
 - Is the patient currently being treated with an antiretroviral therapy and will continue antiretroviral therapy in combination with the requested agent?..... Yes No
 - Have all other causes of weight loss been ruled out?..... Yes No
 - Is the patient receiving specialized nutritional support? **Please note, chart notes are required.**..... Yes No
 - Does the patient have any of the following? Please select all that apply and **submit chart notes for review.**
 - Unintentional weight loss greater than or equal to 10% over 12 months
 - Unintentional weight loss greater than or equal to 7.5% over 6 months
 - Body cell mass (BCM) loss greater than or equal to 5% within 6 months

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- The patient's sex is male and a BCM less than 35% of total body weight and body mass index (BMI) is less than 27 kg/m²
- The patient's sex is female and a BCM less than 23% of total body weight and BMI is less than 27 kg/m²
- The patient's BCM is less than 35% or less than 23% (based on sex) and BMI is less than 27 kg/m²
 - Is there support that the patient's BCM is less than 35% or less than 23% (based on sex) and BMI less than 27 kg/m² are medically appropriate for diagnosing AIDS wasting/cachexia? Yes No
- BMI is less than 20 kg/m²
- None of the above

- Growth hormone deficiency (GHD) or growth failure due to inadequate secretion of endogenous growth hormone (GH)
 - Did the patient have a diagnosis of childhood-onset GHD AND has failed at least one GH stimulation test as an adult? **Please note, chart notes are required** Yes No
 - Does the patient have a low insulin-like growth factor-1 (IGF-1) level?..... Yes No
 - Does the patient have ONE of the following? **Please note, chart notes are required.** Yes No
 - Organic hypothalamic-pituitary disease
 - Pituitary structural lesion or trauma
 - Panhypopituitarism or multiple (greater than or equal to 3) pituitary hormone deficiency (MPHD)?
 - None of the above
 - Does the patient have an established causal genetic mutation OR hypothalamic-pituitary structural defect other than ectopic posterior pituitary? **Please note, chart notes are required.** Yes No
 - Has the patient failed at least TWO GH stimulation tests as an adult? **Please note, chart notes are required.** Yes No
 - Has the patient failed at least ONE GH stimulation test as an adult AND does the patient have an organic pituitary disease? **Please note, chart notes are required.** Yes No
- Short bowel syndrome (SBS)
 - Is the patient receiving specialized nutritional support? **Please note, chart notes are required.**..... Yes No
- Other (Please specify) _____

For All Renewal Requests:

- 16. Has the patient had clinical benefit with the requested agent? Yes No
- 17. Is the patient being monitored for adverse effects of growth hormone (GH) therapy? Yes No

For Renewal Request for Children:

For idiopathic short stature (ISS) requests:

- 18. Has the patient's height increased greater than or equal to 2 cm over the previous year with GH therapy?..... Yes No
- 19. If male, is the patient's bone age less than 16 years AND the patient has open epiphyses? Yes No
- 20. If female, is the patient's bone age less than 15 years AND the patient has open epiphyses? Yes No

For Growth hormone deficiency (GHD) or growth failure due to inadequate secretion of endogenous GH, Noonan's syndrome, SHOX deficiency, Turner syndrome, Small for gestational age (SGA), Renal function impairment with growth failure requests:

- 21. Has the patient's height increased greater than or equal to 2 cm over the previous year with GH therapy?..... Yes No
- 22. Does the patient have closed epiphyses? Yes No

For Renewal Request for Adults:

For AIDS wasting or cachexia:

- 23. Has the patient had clinical benefit with the requested agent (i.e., an increase in weight or weight stabilization)?..... Yes No

For Growth hormone deficiency (GHD) or growth failure due to inadequate secretion of endogenous GH:

- 24. Has the patient's insulin-like growth factor-1 (IGF-1) level been evaluated to confirm the appropriateness of the current dose? Yes No
- 25. Has the patient had clinical benefit with the requested agent (i.e., body composition, hip-to-waist ratio, cardiovascular health, bone mineral density, serum cholesterol, physical strength, or quality of life)?..... Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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