GROWTH HORMONE
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information please visit *www.myprime.com*.

What is the priority level of this request?

☐ Standard
☐ Date of service (if applicable): _____
☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

PATIENT AND INSURANCE INFORMATION **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 #:	

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

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:

☐ AIDS wasting/cachexia
☐ Chronic renal insufficiency
☐ Idiopathic short stature (ISS)
☐ Noonan syndrome
☐ Prader-Willi syndrome
☐ Short bowel syndrome (SBS)
☐ Short stature
☐ SHOX gene deficiency
☐ Small for gestational age (SGA)
☐ Turner syndrome
☐ Growth hormone deficiency (GHD) or growth failure due to inadequate secretion of endogenous growth hormone
☐ Panhypopituitarism or deficiencies in 3 or more pituitary axes
☐ Other (ICD code and description): _____

Medication requested:	Strength:
Dosing schedule:	Quantity per month:

For all requests:

1. Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No
2. What is the patient's weight? _____(kg)
3. Is the patient a child or an adult? Select one: ☐ Child ☐ Adult
4. Is the patient's age within FDA labeling for the requested indication for the requested agent? ..... ☐ Yes ☐ No
   If no, is there information to support use with the requested agent for the patient's age for the requested indication? ..... ☐ Yes ☐ No
   If yes, please provide supporting information: _____
   _____
5. Does the patient have any FDA labeled contraindications to therapy with the requested agent? ..... ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____

Please continue to the next page.

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

6. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist) or has consulted with a specialist in the area of the patient's diagnosis? ☐ Yes ☐ No
7. Please list all reasons for selecting the requested medication, 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). _____
_____
_____
8. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products or over-the-counter products.)

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

For Long-acting growth hormone products (Ngenia, Skytrofa, or Sogroya) requests:

9. Does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to a preferred short-acting GH agent (Omnitrope, Genotropin, Genotropin MiniQuick) that is not expected to occur with the requested agent? **Please note, medical records are required.** ☐ Yes ☐ No
   If yes, please submit medical records.
10. Has the patient received at least 12 months of therapy with a preferred short-acting GH agent (Omnitrope, Genotropin, Genotropin MiniQuick)? ☐ Yes ☐ No
11. Is the requested agent Skytrofa? ☐ Yes ☐ No
    If no, is Skytrofa FDA approved for the requested indication? ☐ Yes ☐ No
    If yes, has the patient received at least 12 months of therapy with Skytrofa? ☐ Yes ☐ No
    If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to Skytrofa that is not expected to occur with the requested agent? **Please note, medical records are required.** ☐ Yes ☐ No
    If yes, please submit medical records.

For Short-acting growth hormone products requests:

12. Does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to a preferred agent, (Omnitrope, Genotropin, and Genotropin MiniQuick), that is not expected to occur with the requested nonpreferred agent? **Please note, medical records are required**. ☐ Yes ☐ No
    If yes, please submit medical records.
    If no, is there information to support the efficacy of the requested nonpreferred agent over a preferred agent, (Omnitrope, Genotropin, and Genotropin MiniQuick), for the intended diagnosis? **Please note, medical records are required.** ☐ Yes ☐ No
    If yes, please submit medical records.

For children:

13. Is the patient a newborn (4 months of age or less)? ☐ Yes ☐ No
    If yes, does the patient have hypoglycemia? ☐ Yes ☐ No
    If yes, does the patient have a serum growth hormone (GH) concentration less than or equal to 5 mcg/L? ☐ 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 yes, does the patient have a growth hormone (GH) concentration less than 20 mcg/L? ☐ Yes ☐ No
    If yes, does the patient have a known metabolic disorder? ☐ Yes ☐ No
    If yes, does the patient have a reduced IGFBP-3 level (e.g., less than -2.0 SD)? ☐ Yes ☐ No
14. Does the patient have extreme short stature (e.g., height less than or equal to -3 SD), normal nutrition, significantly reduced IGF-1 and IGFBP-3 (e.g., less than -2 SD) and delayed bone age? ☐ Yes ☐ No

Please continue to the next page.

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

15. Does the patient have any of the following? Select all that apply.
    - ☐ Height more than 2 standard deviations (SD) below the mean for age and sex
    - ☐ Height more than 1.5 SD below the midparental height
    - ☐ Decrease in height of more than 0.5 SD over one year
    - ☐ Height velocity (HV) more than 2 SD below the mean over one year
    - ☐ Height velocity (HV) more than 1.5 SD below the mean 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
    - ☐ Height velocity (HV) less than 5.5 cm/year (less than 2.2 inches/year)
    - ☐ Height velocity (HV) less than 5 cm/year (less than 2 inches/year)
16. For age 6 years to puberty:
    Patient's sex is female: Is the patient's height velocity (HV) less than 4.5 cm/year (less than 1.8 inches/year)?.. ☐ Yes ☐ No
    Patient's sex is male: Is the patient's height velocity (HV) less than 4 cm/year (less than 1.6 inches/year)?..... ☐ Yes ☐ No
17. How many growth hormone (GH) stimulation tests has the patient failed (peak GH value of less than 10 mcg after stimulation or otherwise considered abnormal as determined by testing lab)?
    Please select one: ☐ None ☐ 1 ☐ 2 ☐ Other: _____
18. Does the patient have any of the following? Select all that apply.
    - ☐ A pathology of the central nervous system ☐ History of irradiation ☐ A genetic defect
    - ☐ A pituitary abnormality and a known deficit of at least one pituitary hormone other than growth hormone
    - ☐ Other pituitary hormone defect (e.g., multiple pituitary hormone deficiency [MPHD])

For short bowel syndrome (SBS):

19. Is the patient receiving specialized nutritional support? ..... ☐ Yes ☐ No

For panhypopituitarism or deficiencies in 3 or more pituitary axes:

20. Is the patient's serum IGF-I level low (below the age- and sex-appropriate reference range) when off growth hormone therapy? ..... ☐ Yes ☐ No

For chronic renal insufficiency:

21. Is the patient's height velocity (HV) for age less than -1.88 standard deviations (SD) OR HV for age is less than the third percentile? ..... ☐ Yes ☐ No
22. Have all other etiologies for growth impairment been addressed? ..... ☐ Yes ☐ No

For patients small for gestational age (SGA):

23. Does the patient have a documented birth weight and/or birth length that is 2 or more standard deviations below the mean for gestational age? ..... ☐ Yes ☐ No
24. 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 below the mean for age and sex? ..... ☐ Yes ☐ No

For idiopathic short stature (ISS):

25. Is the patient's height less than or equal to -2.25 SD below the corresponding mean for age and sex? ..... ☐ Yes ☐ No
26. Does the patient have open epiphyses? ..... ☐ Yes ☐ No
27. Does the patient have a predicted adult height that is below the normal range? ..... ☐ Yes ☐ No
    If yes, is the patient's sex male and predicted adult height is less than 63, OR 2) the patient's sex is female and predicted adult height is less than 59 inches? ..... ☐ Yes ☐ No
    If no, is the patient more than 2 SD below their mid-parental target height? ..... ☐ Yes ☐ No
28. 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

For adults:

For AIDS wasting/cachexia:

29. Is the patient currently treated with antiretroviral therapy and will continue antiretroviral therapy in combination with the requested agent? ..... ☐ Yes ☐ No
30. Please provide the patient's percent body cell mass (BCM) of total body weight and body mass index (BMI):
    BCM: _____ % BMI: _____ kg/m^2

Please continue to the next page.

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

31. Are the patient's BCM and BMI values medically appropriate for diagnosing AIDS wasting/cachexia for the patient's sex? ☐ Yes ☐ No

    If yes, please explain:_____

    _____

32. Has the patient experienced any of the following:

    ☐ 10% unintentional weight loss over 12 months

    ☐ 7.5% unintentional weight loss over 6 months

    ☐ A BCM loss greater than or equal to 5% within 6 months

33. Have all other causes of weight loss been ruled out? ☐ Yes ☐ No

For short bowel syndrome (SBS):

34. Is the patient receiving specialized nutritional support? ☐ Yes ☐ No

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

35. Has the patient had a diagnosis of childhood-onset growth hormone deficiency? ☐ Yes ☐ No

36. How many growth hormone stimulation tests has the patient failed as an adult? Please select one:

    ☐ None ☐ 1 ☐ 2 ☐ Other: _____

37. Does the patient have a low insulin-like growth factor-1 (IGF-1) level? ☐ Yes ☐ No

38. Does the patient have any of the following? Select all that apply.

    ☐ Organic hypothalamic-pituitary disease

    ☐ A pituitary structural lesion or trauma

    ☐ An established causal genetic mutation OR hypothalamic-pituitary structural defect other than ectopic posterior pituitary

    ☐ Panhypopituitarism or multiple (3 or more) pituitary hormone deficiency

For renewal requests:

39. Is the patient being monitored for adverse effects of growth hormone? ☐ Yes ☐ No

40. Has the patient had clinical benefit with the requested agent? ☐ Yes ☐ No

For children:

41. Does the patient have closed epiphyses? ☐ Yes ☐ No

42. Has the patient's height increased greater than or equal to 2 cm over the previous year with GH therapy? ☐ Yes ☐ No

For idiopathic short stature (ISS):

43. Is the patient's bone age less than 16 years old in patients with a sex of male and 15 years in patients with a sex of female AND the patient has open epiphyses? ☐ Yes ☐ No

For adults:

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

44. Has the patient had clinical benefits 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

45. Has the patient's IGF-I level been evaluated to confirm the appropriateness of the current dose? ☐ Yes ☐ No

For AIDS wasting/cachexia:

46. Is the patient currently treated with antiretroviral therapy and will continue antiretroviral therapy in combination with the requested agent? ☐ Yes ☐ No

47. Has the patient had clinical benefit with the requested agent (weight increase or weight stabilization)? ☐ Yes ☐ No

Please continue to the next page.

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

For Capital Health Plan (CHP) members:

48. Has the patient been previously approved to receive the requested agent through the completion of a step-therapy protocol by a separate health coverage plan? **Documentation originating from a previous health coverage plan must be provided.** ☐ Yes ☐ No

    If yes, has the health coverage plan paid for the drug on the insured's behalf during the 90 days immediately before the request? **Documentation originating from a previous health coverage plan must be provided.** ☐ Yes ☐ No

Please fax or mail this form to:
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TOLL FREE

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