Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

GROWTH HORMONE
Prior Authorization Form

Humatrope, Norditropin FlexPro, Genotropin, Nutropin AQ, Omnitrope, Saizen, Zomacton

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Present Height (include units):	Percentile:	Standard Deviation Score:
Pretreatment growth velocity: (Initial Requests)	Growth velocity on treatment:	Recent skeletal bone age: (chart documentation)

Has the member had evidence of active malignancy within the past year? □ Yes □ No

Does the member have active proliferative or severe non-proliferative diabetic retinopathy? □ Yes □ No

Diagnosis (Please Check One)
To allow for complete review, please provide CHART DOCUMENTATION as described below.

□ **Child or Adolescent with classic Growth Hormone Deficiency**

Chart documentation should include: diagnosis, growth chart, results of 2 provocative growth hormone stimulation tests, pretreatment growth velocity, comparison of skeletal (bone) age compared to chronological age, treatment plan.

Does the member have a history of irradiation or multiple pituitary hormone deficiency? □ Yes □ No

Please provide names and dates of specific growth hormone stimulation tests:_____

☐ **Child with growth retardation due to Chronic Renal Insufficiency and awaiting kidney transplantation**	*Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan.* Anticipated date of renal transplant:_____
☐ **Female child with Turner's Syndrome/Noonan Syndrome**	*Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan.*
☐ **Child with Short Stature Homeobox-containing Gene (SHOX) deficiency**	*Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, comparison of skeletal (bone) age compared to chronological age, and treatment plan.*
☐ **Child with Prader-Willi Syndrome**	*Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan.*

Please provide the member's BMI: _____

Does the member have severe respiratory impairment or a history of upper airway obstruction or sleep apnea? ☐ Yes ☐ No

☐ **Child born Small for Gestational Age (SGA)**	*Chart documentation should include diagnosis, birth weight and length, gestational age, growth chart, pretreatment growth velocity, treatment plan.*

Gestational age:_____ Birth Weight:_____ Birth Length:_____

Height or weight percentile or standard deviation at birth: _____

☐ **Adult with Growth Hormone Deficiency with childhood onset** **OR**	*Chart documentation should include: diagnosis, diagnosis as a child, results of reassessment of provocative growth hormone stimulation test using the insulin tolerance test unless contraindicated, documentation explaining if patient has reached adult peak bone mass, treatment plan.*
☐ **Adult with Growth Hormone Deficiency with adult onset**	*Chart documentation should include: underlying cause of Growth Hormone Deficiency, if underlying cause is unknown - evidence of hypothalamic pituitary disease, documentation of at least one other hormone deficiency (other than GH) such as TSH, ACTH, or gonadotropins (except for prolactin), results of provocative growth hormone stimulation test using the insulin tolerance test, if the member has diabetes – documentation that their diabetes is controlled and that the patient does not have diabetes with unstable proliferative retinopathy, treatment plan.*

Please indicate cause of growth hormone deficiency (if applicable): _____

Serum IGF-I level while NOT on growth hormone (if applicable): _____

Has the member been off growth hormone for at least 1 month (for adult with childhood onset)? ☐ Yes ☐ No

Please provide names and dates of specific growth hormone stimulation tests (if applicable):_____

Does the member have a pituitary adenoma?	☐ Yes ☐ No
If yes, has the tumor size remained stable for 1 year?	☐ Yes ☐ No

Please indicate if the member has any of the following (and submit chart documentation to support):

- ☐ Severe growth hormone deficiency in childhood due to genetic cause
- ☐ Severe growth hormone deficiency and receipt of high-dose cranial radiation therapy
- ☐ Structural hypothalamic-pituitary disease
- ☐ Central nervous system tumor(s)
- ☐ Deficiencies in the following pituitary hormones:
  - ☐ Adrenocorticotropin hormone (ACTH)
  - ☐ Thyroid stimulating hormone (TSH)
  - ☐ Prolactin
  - ☐ Arginine vasopression (VAP)
  - ☐ Gonadotropins [leutinizing hormone (LH) and follicle stimulating hormone (FSH)]

☐ **Other**_____

Chart documentation describing underlying condition and rationale for growth hormone treatment.

Patient Medical Chart Information Sent? ☐ **Yes** ☐ **No**

Please provide any additional information which should be considered in the space below: