Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**
Growth Hormone® (somatotropin)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞

MD _____

Signature _____

Name _____

Address _____

℞ COMPLETE PRIOR AUTHORIZATION FORMS

Dx: HYPOPITUITARISM

ICD 10: E 23.0

MD _____

Signature _____

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone	Fax

Member Information

Last Name:	First Name
Member ID Number	DOB:

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Genotropin, Humatrope, Nutropin/Nutropin AQ, Omnitrope, Saizen, Tev-Tropin Prior Authorization Form

Initial Therapy: Pediatric Patients (Younger than 18 Years of Age) You must answer ALL of the following questions		
1. Has the patient tried and had an inadequate response or intolerance to Norditropin for at least 3 months?	Y	N
2. Is the prescriber a pediatric endocrinologist or pediatric nephrologist in the case of chronic kidney disease?	Y	N

3. What is the condition for which growth hormone therapy will be requested? **(Please circle.)**

- Growth hormone deficiency without organic pituitary disease
- Growth hormone deficiency with organic pituitary disease
- Idiopathic short stature
- Short stature due to chronic kidney disease
- Small for gestational age (SGA)
- Turner's syndrome
- Prader-Willi syndrome
- Noonan syndrome
- Short stature homeobox (SHOX) deficiency
- Other _____

GHD WITHOUT ORGANIC PITUITARY DISEASE		
4. Did the patient have two provocative tests with results below 10 ng/mL (i.e., L-Dopa, insulin-induced hypoglycemia, arginine, glucagon, or clonidine)? *Documentation must be submitted.* *NOTE: If an insulin tolerance test is performed, it must include plasma glucose levels obtained throughout the duration of the test. A 50% decrease in plasma glucose levels or a plasma glucose level of less than 40 mg/dl must be achieved, documented, and submitted for the sequential GH measurements to be interpretable.*	Y	N
5. Did the patient have one provocative stimulation test with results less than 15 ng/mL (i.e., L-Dopa, insulin-induced hypoglycemia, arginine, glucagon, or clonidine)? *Documentation must be submitted.*	Y	N
6. Did the patient have a low level of insulin-like growth factor-1 (IGF-1) for the patient's age, gender, and pubertal status? *Documentation must be submitted.*	Y	N
7. Did the patient have a low level of IGFBP-3 (insulin-like growth factor binding protein-3)? *Documentation must be submitted.*	Y	N
8. Is the patient's height below the third percentile for their age and gender related height? *Documentation must be submitted.*	Y	N
9. Did the patient have a decrease in growth velocity that was at least 2 standard deviations (SD) below the age-related mean measured over 1 year? *Documentation must be submitted.*	Y	N
10. Does the patient have delayed skeletal maturation at least 2 SD below the age/gender related mean? *Documentation must be submitted.*	Y	N
11. Are bone epiphyses still open if 10 years of age or older? *Documentation must be submitted.*	Y	N
GHD WITH ORGANIC PITUITARY DISEASE		
4. Does the patient have organic pituitary disease (e.g., head trauma, cranial irradiation, stroke, hypopituitarism, panhypopituitarism, known mutations, irreversible and/or post-surgery hypothalamic-pituitary lesions, embryopathic / congenital defects of the pituitary, or septo-optic dysplasia)?	Y	N
5. Is the serum IGF-1 level lower than the age-specific lower limit of normal? *Documentation must be submitted.*	Y	N
6. Does the patient have an MRI or CT of the head, which shows pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, and/or ectopic posterior pituitary "bright spot"? *Documentation must be submitted.*	Y	N
7. After the CT of the head or MRI, did the patient have one provocative stimulation test less than 15 ng/ml? *Documentation must be submitted.*	Y	N
IDIOPATHIC SHORT STATURE		
4. Is the patient's height at least 2.25 standard deviation score below the mean chronological age and sex? *Documentation must be submitted.*	Y	N
5. Have other causes such as genetic, metabolic, or organ system dysfunction been ruled out? *Documentation must be submitted.*	Y	N
CHRONIC KIDNEY DISEASE		
4. Has the patient received a renal transplant?	Y	N
5. Is the patient's height below the 3rd percentile for their chronological age and gender? *Documentation must be submitted.*	Y	N
SMALL FOR GESTATIONAL AGE (SGA)		
4. Was the patient born as 2 or more standard deviations below the mean in birth weight and/or birth length for gestational age? *Documentation must be provided.*	Y	N
5. Did the patient fail to catch up in growth by two years of age, defined as two or more SDs below the mean in birth weight and/or birth height for chronological age and gender? *Documentation must be provided.*	Y	N
TURNER'S SYNDROME		
4. Has there been genetic testing to confirm 45, XO genotype? *Documentation must be provided.*	Y	N
5. Does the patient's height fall below the 5th percentile for chronological age and gender? *Documentation must be provided.*	Y	N

PRADER-WILLI SYNDROME		
4. Has the diagnosis of Prader-Willi syndrome been confirmed by appropriate genetic testing (i.e., loss of gene function associated with chromosome 15 such as translocation or maternal uniparental disomy)? *Documentation must be provided.*	Y	N
5. Has the patient undergone assessment of underlying airway obstruction including sleep studies? *Documentation must be provided.*	Y	N
6. Does the patient have any of the following contraindications to GH therapy: severe obesity (e.g., weight is greater than 225 percent of ideal body weight), history of upper airway obstruction, respiratory compromise, or severe sleep apnea?	Y	N
SHORT STATURE HOMEOBOX (SHOX) DEFICIENCY		
4. Has short stature homeobox (SHOX) deficiency been confirmed by a chromosome analysis?	Y	N

Initial Therapy: Adult Patients (18 Years of Age and Older) You must answer ALL of the following questions		
1. Has the patient tried and had an inadequate response or intolerance to Norditropin for at least 3 months?	Y	N
2. What is the condition for which growth hormone therapy will be requested? **(Please circle.)** • Growth hormone deficiency alone or with multiple hormone deficiencies (such as hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma • Childhood-onset growth hormone deficiency as a result of congenital, acquired, or idiopathic causes • Growth hormone deficiency due to organic pituitary disease • Other _____		
GHD ALONE OR WITH HORMONAL DEFICIENCIES		
3. Is the patient's serum IGF-1 concentration lower than the age-specific lower limit of normal in a patient who has organic pituitary disease? *Documentation must be provided.*	Y	N
4. Did the patient have a subnormal GH response to insulin-induced hypoglycemia (less than 5.1 ng/mL) or arginine-GHRH (less than 4.1 ng/mL)? *Documentation must be provided.* *NOTE: If an insulin tolerance test is performed, it must include plasma glucose levels obtained throughout the duration of the test. A 50% decrease in plasma glucose levels or a plasma glucose level of less than 40 mg/dL must be achieved, documented, and submitted for the sequential GH measurements to be interpretable.*	Y	N
CHILDHOOD ONSET GHD		
3. Has the patient been retested at least 1 month after GH therapy has been discontinued and final height has been achieved and have subnormal responses been demonstrated by two standard GH stimulation tests (ITT, GHRH + ARG, Glucagon, Arginine)?	Y	N
GHD WITH ORGANIC PITUITARY DISEASE		
3. Does the patient have organic pituitary disease (e.g. head trauma, cranial irradiation, stroke, hypopituitarism, panhypopituitarism, known mutations, irreversible and/or post-surgery hypothalamic-pituitary lesions, embryopathic / congenital defects of the pituitary, septo-optic dysplasia)? *Documentation must be provided.*	Y	N
4. Are current or past IGF-I levels below the age- and sex-appropriate reference range without GH therapy? *Documentation must be provided.*	Y	N
5. Has a subnormal GH response to insulin-induced hypoglycemia (less than 5.1 ng/ml) or arginine-GHRH (less than 4.1 ng/ml) been demonstrated?	Y	N

Renewal Therapy You must answer ALL of the following questions		
1. What is the condition for which growth hormone therapy will be requested? **(Please circle.)** • Pediatric human growth hormone deficiency • Small for gestational age (SGA) • Idiopathic short stature (ISS) • Growth failure due to Turner's syndrome • Noonan syndrome • Short Stature Homeobox (SHOX) deficiency • Short stature due to chronic renal failure • Prader-Willi syndrome • Adult growth hormone deficiency • Other _____		
PEDIATRIC PATIENTS (YOUNGER THAN 18 YEARS OF AGE) **You must answer ALL of the following questions**		
2. Does the patient have open bone epiphyses?	Y	N
3. What is the patient's gender? **(Please circle.)** • Male • Female		
4. Does the patient have a bone age of up to 16 years and a growth response of at least 4.5 cm/yr (prepubertal growth rate) or at least 2.5 cm/yr (post-pubertal growth rate)?	Y	N
5. Does the patient have a bone age of up to 14 years and a growth response of at least 4.5 cm/yr (prepubertal growth rate) or at least 2.5 cm/yr (post-pubertal growth rate)?	Y	N
PRADER-WILLI SYNDROME		
6. Is the patient 16 years of age or younger?	Y	N
7. Is the patient 14 years of age or younger?	Y	N
8. Does the patient have an increase in lean body mass, decrease in fat, or maintenance of benefit?	Y	N
ADULT PATIENTS (18 YEARS OF AGE OR OLDER) **You must answer ALL of the following questions**		
2. Has the patient experienced a clinical benefit (e.g., increase in total lean body mass, increase in IGF-1 and IGFBP-3 levels, or increase in exercise capacity)?	Y	N

Zorbitive Prior Authorization Form

Initial Therapy You must answer ALL of the following questions		
1. Does the patient have a diagnosis of short bowel syndrome as a result of resected or damaged bowel?	Y	N
2. Has the patient experienced symptoms of chronic diarrhea, weight loss, electrolyte imbalances, malnutrition, dehydration, or malabsorption of fats, vitamins and minerals?	Y	N
3. Is the patient receiving specialized nutritional support (i.e. parenteral nutrition)? *Documentation must be provided.*	Y	N

Renewal Therapy You must answer ALL of the following questions		
1. Has the patient experienced clinical benefit while on therapy (e.g., decrease in intravenous nutrition requirements)? *Documentation must be provided.*	Y	N

Norditropin Prior Authorization Form

Initial Therapy: Pediatric Patients (Younger than 18 Years of Age) You must answer ALL of the following questions		
1. Is the prescriber a pediatric endocrinologist or pediatric nephrologist in the case of chronic kidney disease?	Y	N
2. What is the condition for which growth hormone therapy will be requested? **(Please circle.)** • Growth hormone deficiency without organic pituitary disease • Growth hormone deficiency with organic pituitary disease • Idiopathic short stature • Short stature due to chronic kidney disease • Small for gestational age (SGA) • Turner's syndrome • Prader-Willi syndrome • Noonan syndrome • Short stature homeobox (SHOX) deficiency • Other _____		
GHD <u>WITHOUT</u> ORGANIC PITUITARY DISEASE		
3. Did the patient have two provocative tests with results below 10 ng/mL (i.e., L-Dopa, insulin-induced hypoglycemia, arginine, glucagon, or clonidine)? *Documentation must be submitted.* *NOTE: If an insulin tolerance test is performed, it must include plasma glucose levels obtained throughout the duration of the test. A 50% decrease in plasma glucose levels or a plasma glucose level of less than 40 mg/dl must be achieved, documented, and submitted for the sequential GH measurements to be interpretable.*	Y	N
4. Did the patient have one provocative stimulation test with results less than 15 ng/mL (i.e., L-Dopa, insulin-induced hypoglycemia, arginine, glucagon, or clonidine)? *Documentation must be submitted.*	Y	N
5. Did the patient have a low level of insulin-like growth factor-1 (IGF-1) for the patient's age, gender, and pubertal status? *Documentation must be submitted.*	Y	N
6. Did the patient have a low level of IGFBP-3 (insulin-like growth factor binding protein-3)? *Documentation must be submitted.*	Y	N
7. Is the patient's height below the third percentile for their age and gender related height? *Documentation must be submitted.*	Y	N
8. Did the patient have a decrease in growth velocity that was at least 2 standard deviations (SD) below the age-related mean measured over 1 year? *Documentation must be submitted.*	Y	N
9. Does the patient have delayed skeletal maturation at least 2 SD below the age/gender related mean? *Documentation must be submitted.*	Y	N
10. Are bone epiphyses still open if 10 years of age or older? *Documentation must be submitted.*	Y	N
GHD <u>WITH</u> ORGANIC PITUITARY DISEASE		
3. Does the patient have organic pituitary disease (e.g., head trauma, cranial irradiation, stroke, hypopituitarism, panhypopituitarism, known mutations, irreversible and/or post-surgery hypothalamic-pituitary lesions, embryopathic / congenital defects of the pituitary, or septo-optic dysplasia)?	Y	N
4. Is the serum IGF-1 level lower than the age-specific lower limit of normal? *Documentation must be submitted.*	Y	N
5. Does the patient have an MRI or CT of the head, which shows pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, and/or ectopic posterior pituitary "bright spot"? *Documentation must be submitted.*	Y	N
6. After the CT of the head or MRI, did the patient have one provocative stimulation test less than 15 ng/ml? *Documentation must be submitted.*	Y	N
IDIOPATHIC SHORT STATURE		
3. Is the patient's height at least 2.25 standard deviation score below the mean chronological age and sex? *Documentation must be submitted.*	Y	N

4. Have other causes such as genetic, metabolic, or organ system dysfunction been ruled out? *Documentation must be submitted.*	Y	N
CHRONIC KIDNEY DISEASE		
3. Has the patient received a renal transplant?	Y	N
4. Is the patient's height below the 3rd percentile for their chronological age and gender? *Documentation must be submitted.*	Y	N
SMALL FOR GESTATIONAL AGE (SGA)		
3. Was the patient born as 2 or more standard deviations below the mean in birth weight and/or birth length for gestational age? *Documentation must be provided.*	Y	N
4. Did the patient fail to catch up in growth by two years of age, defined as two or more SDs below the mean in birth weight and/or birth height for chronological age and gender? *Documentation must be provided.*	Y	N
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PRADER-WILLI SYNDROME		
3. Has the diagnosis of Prader-Willi syndrome been confirmed by appropriate genetic testing (i.e., loss of gene function associated with chromosome 15 such as translocation or maternal uniparental disomy)? *Documentation must be provided.*	Y	N
4. Has the patient undergone assessment of underlying airway obstruction including sleep studies? *Documentation must be provided.*	Y	N
5. Does the patient have any of the following contraindications to GH therapy: severe obesity (e.g., weight is greater than 225 percent of ideal body weight), history of upper airway obstruction, respiratory compromise, or severe sleep apnea?	Y	N
SHORT STATURE HOMEOBOX (SHOX) DEFICIENCY		
3. Has short stature homeobox (SHOX) deficiency been confirmed by a chromosome analysis?	Y	N

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2. Is the patient's serum IGF-1 concentration lower than the age-specific lower limit of normal in a patient who has organic pituitary disease? *Documentation must be provided.*	Y	N
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GHD WITH ORGANIC PITUITARY DISEASE		
2. Does the patient have organic pituitary disease (e.g. head trauma, cranial irradiation, stroke, hypopituitarism, panhypopituitarism, known mutations, irreversible and/or post-surgery hypothalamic-pituitary lesions, embryopathic / congenital defects of the pituitary, septo-optic dysplasia)? *Documentation must be provided.*	Y	N
3. Are current or past IGF-I levels below the age- and sex-appropriate reference range without GH therapy? *Documentation must be provided.*	Y	N
4. Has a subnormal GH response to insulin-induced hypoglycemia (less than 5.1 ng/ml) or arginine-GHRH (less than 4.1 ng/ml) been demonstrated?	Y	N

Renewal Therapy **You must answer ALL of the following questions**		
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5. Does the patient have a bone age of up to 14 years and a growth response of at least 4.5 cm/yr (prepubertal growth rate) or at least 2.5 cm/yr (post-pubertal growth rate)?	Y	N
PRADER-WILLI SYNDROME		
6. Is the patient 16 years of age or younger?	Y	N
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ADULT PATIENTS (18 YEARS OF AGE OR OLDER) **You must answer ALL of the following questions**		
2. Has the patient experienced a clinical benefit (e.g., increase in total lean body mass, increase in IGF-1 and IGFBP-3 levels, or increase in exercise capacity)?	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

Prescriber or Authorized Signature **Date**

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

Please Note: Medical Necessity Prior Authorization may be utilized to override both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION FORM:
COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	