

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 08

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Human Growth Hormone (Norditropin, Nutropin)

\*This medication must be dispensed at a participating Specialty Pharmacy

Member Name: \_\_\_\_\_ Member #: \_\_\_\_\_ - \_\_\_\_\_

DOB: \_\_\_\_\_ Sex: \_\_\_\_\_ Provider Phone: \_\_\_\_\_

Provider Name: \_\_\_\_\_ Provider Fax: \_\_\_\_\_

Provider Office Contact Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Drug Requested (please choose one):

Norditropin:  5mg cartridge  4mg vial  5mg nordiflex pen  
 15mg cartridge  8mg vial  10mg nordiflex pen  15mg nordiflex penNutropin:  10mg vial  5mg vialNutropin AQ:  10mg vial  10mg cartridge  20mg cartridge

### Priority Health Precertification Requirements:

 **Pediatrics**

Initial treatment is being used for any of the following indications:

- 1.
- 
- Idiopathic Growth Hormone deficiency exists

Serum growth hormone concentration (GHC) of &lt;7-10 ng/ml peak level following stimulation testing.

Date: \_\_\_\_\_ Results: \_\_\_\_\_

Appropriate medical work up has been performed, to include the following:

- 
- Six month trial period on the drug
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- 
- Absolute growth <7 cm/yr before 3 years of age.
- 
- 
- Absolute growth <4.5 cm/yr without growth hormone after 3 years of age at puberty.
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- 
- Comparison of skeletal age by x-ray of the left hand and wrist compared to chronological age shows >2 standard deviations below normal.
- 
- 
- Failure of
- TWO**
- of the follow pharmacologic stimulation tests for growth hormone response to produce a serum growth hormone concentration of >7-10 ng/ml:
- 
- 
- Insulin-induced hypoglycemia
- 
- 
- Levodopa
- 
- 
- L-arginine HCL
- 
- 
- Clonidine
- 
- 
- Glucagon

- 2.
- 
- Turner's Syndrome

Continued treatment:

Growth hormone therapy is continued beyond six months only if all of the following criteria are met:

- 
- Growth velocity has increased by at least 2 cm/yr
- 
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- Patient is compliant with the drug regimen
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- 
- Bone age remains below 13 years in girls and 15 years in boys

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- Adults** – For adults age 18 and older **both** of the following must apply:
- Documented growth hormone deficiency. Growth hormone deficiency must be documented by a suboptimal response (<3 mcg/l) to a hypoglycemic challenge. For patients where insulin-induced hypoglycemia is contraindicated (e.g. CAD or seizure disorder) other accepted stimuli such as levodopa, argine, GHRH, glucagons or clonidine are acceptable.

AND

One of the following:

- Hypothalamic pituitary disease resulting from tumor or infarct;
- History of cranial or radiation during either childhood or adulthood resulting in GH deficiency;
- Pituitary surgery resulting in GH deficiency; or
- Continuing treatment of childhood onset growth hormone deficiency.

Note:

- Please fax current bone age study and growth chart for pediatric request
- When granted, approval authorization will be for one year; please complete PA form annually

**For Internal Use Only**

Original Date of Req: \_\_\_\_\_ Non-Urgent: \_\_\_ Urgent: \_\_\_ Retro: \_\_\_ Method: Phone \_\_\_ Fax \_\_\_ Ltr \_\_\_ Coord. Initial \_\_\_  
 Approved: \_\_\_ Denied: \_\_\_ Letter Type: Denial \_\_\_ 48 hr \_\_\_ Off-Label Use \_\_\_ Verbal: Y \_\_\_ N \_\_\_ Inquiry number: \_\_\_\_\_  
 Product: HMO \_\_\_ PPO \_\_\_ ASO \_\_\_ POS \_\_\_ Caid \_\_\_ MlChild \_\_\_ Mcare \_\_\_ McarePlus \_\_\_ McareRX \_\_\_ McareValue \_\_\_ EGMcare \_\_\_  
 Formulary (11/0030/R0) \_\_\_\_\_ Non-Formulary (11/0032/R0) \_\_\_\_\_  
 Dte Addt Info Req \_\_\_\_\_ by: Phone \_\_\_ Fax \_\_\_ Dte 48/OL Ltr sent: \_\_\_\_\_ Dte 2nd 48/OL Ltr Sent (Caid only) \_\_\_\_\_  
 Date All Info Recvd \_\_\_\_\_ Date of Decision to Deny: \_\_\_\_\_ RPh Initials: \_\_\_\_\_  
 Notified: \_\_\_\_\_ of Denial on: \_\_\_\_\_ by: Ph \_\_\_ Fax \_\_\_