

Pharmacy

PRIOR AUTHORIZATION FORM

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

Growth Hormone

 URGENT (life threatening)

 Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 Provider Signature

 Date

PRODUCT INFORMATION

<input type="checkbox"/> chorionic gonadotropin	<input type="checkbox"/> Norditropin Flexpro 15 mg/1.5mL	Dose: _____
<input type="checkbox"/> Genotropin	<input type="checkbox"/> Norditropin Flexpro 5 mg/1.5mL	Start Date: _____
<input type="checkbox"/> Genotropin Miniquick	<input type="checkbox"/> Nutropin Inj 10 mg	
<input type="checkbox"/> Humatrope	<input type="checkbox"/> Nutropin AQ Pen	
<input type="checkbox"/> Humatrope Combo Pack	<input type="checkbox"/> Serostim	
	<input type="checkbox"/> Zorbtive	

Coverage duration: 1 year, when approved

BILLING INFORMATION

Place of administration:

Self-administered
 Provider's Office
 Outpatient Infusion Center
 Center Name: _____
 Home Infusion
 Agency Name: _____

Billing Options:

Physician buy and bill
 Preferred Specialty Vendor
 Other: _____

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for growth hormone requires the following information to certify:

Patient must have met the following requirements:

- Must be prescribed by a pediatric endocrinologist or pediatric nephrologist
- **Indications for children**
 1. Growth hormone deficiency
 - Height is less than the 5th percentile for age/sex
 - Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less than 10th percentile for bone age and gender
 - Growth plates must be open
 - Bone age must be a minimum of 1 year behind chronological age (unless growth hormone deficiency is related to pituitary surgery, radiation therapy, or with precocious puberty)
 - Must have a documented GH deficiency via 2 growth hormone stimulation tests below 10 ng/mL **or** GH stimulation test level < 15 ng/mL + IGF-1 and IGF-PB3 levels below normal for bone age and sex
 - Decreased muscle tone by exam
 2. Turner's syndrome
 - Height is less than 10th percentile
 - Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less than 10th percentile for bone age and gender
 - Growth plates must be open
 - Bone age must be a minimum of 1 year behind chronological age (unless growth hormone deficiency is related to pituitary surgery, radiation therapy, or with precocious puberty)
 - Must have a documented GH deficiency via 2 growth hormone stimulation tests below 10 ng/mL **or** GH stimulation test level < 15 ng/mL + IGF-1 and IGF-PB3 levels below normal for bone age and sex
 - Decreased muscle tone by exam
 3. Pre-transplant chronic renal insufficiency
 - Height is less than the 5th percentile for age/sex
 - Patient is receiving weekly dialysis or serum creatinine is less than 2 mg/dL
 - Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less than 10th percentile for bone age and gender
 - Growth plates must be open
 - Bone age must be a minimum of 1 year behind chronological age (unless growth hormone deficiency is related to pituitary surgery, radiation therapy, or with precocious puberty)
 - Must have a documented GH deficiency via 2 growth hormone stimulation tests below 10 ng/mL **or** GH stimulation test level < 15 ng/mL + IGF-1 and IGF-PB3 levels below normal for bone age and sex
 - Decreased muscle tone by exam
- **Benefit exclusions for children**
 1. Constitutional growth delay
 2. Patients with acute or chronic catabolic illness
- **Growth Hormone Replacement in adults at least 18 years of age**
 1. Documented growth hormone deficiency by:
 - suboptimal response (less than 3 mcg/L) to a hypoglycemic challenge (unless contraindicated, then can use other accepted method), **or**
 - at least 2 other pituitary-related hormone deficiencies and an abnormally low IGF, **and one** of the following:
 - Hypothalamic pituitary disease resulting from tumor or infarct
 - History of cranial irradiation during childhood or adulthood resulting in GH deficiency
 - Pituitary surgery resulting in GH deficiency
 - Continuing treatment of childhood onset GH deficiency
- **Benefit exclusions for adults**
 1. Adults treated during childhood without documented evidence of persistent GH deficiency
 2. Physiologic reductions in growth hormone related to aging
 3. Treatment of Turner's syndrome or cystinosis

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATIONAuthorization for growth hormone requires the following information to certify:

FOR CHILDREN**A. What is the patient's diagnosis?**

- a. Growth hormone deficiency ICD code: _____
i. Height is less than the 5th percentile for age/sex
- b. Turner's syndrome ICD code: _____
i. Height is less than 10th percentile
- c. Pre-transplant chronic renal insufficiency ICD code: _____
i. Height is less than the 5th percentile for age/sex
and one of the following:
ii. Patient is receiving weekly dialysis
iii. serum creatinine is less than 2 mg/dL
- d. Other: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

B. Submit untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less than 10th percentile for bone age and gender**C. Are the patient's growth plates open?**

- Yes
 No – Rationale for use: _____

D. Is the patient's bone age at least 1 year behind chronological age?

- Yes
 No,
 Growth hormone deficiency is related to pituitary surgery, radiation therapy, or precocious puberty
 None of the above – Rationale for use: _____

E. Documentation for one of the following is attached:

- growth hormone deficiency via 2 growth hormone stimulation tests below 10 ng/mL
 growth hormone stimulation test level less than 15 ng/mL + IGF-1 and IGF-PB3 levels below normal bone age and sex
 None of the above attached – Rationale for use: _____

F. By exam, does the patient have decreased muscle tone?

- Yes
 No – Rationale for use: _____

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

 Authorization for growth hormone requires the following information to certify:

FOR ADULTS AGE 18 YEARS AND OLDER
A. What is the patient's diagnosis?

- a. Growth hormone deficiency ICD code: _____
 GH deficiency is documented by which of the following?
- i. suboptimal response (less than 3 mcg/L) to a hypoglycemic challenge (unless contraindicated, then can use other accepted method)
- or**
- ii. at least 2 other pituitary-related hormone deficiencies and an abnormally low IGF, **and** one of the following:
1. Hypothalamic pituitary disease resulting from tumor or infarct
 2. History of cranial irradiation during childhood or adulthood resulting in GH deficiency
 3. Pituitary surgery resulting in GH deficiency
 4. Continuing treatment of childhood onset GH deficiency
- b. *Other:* _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX