

Pharmacy

Prior Authorization Form

Last Reviewed: Sept. & \$11

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/AQ, Genotropin, Humatrope, Omnitrope, Saizen, Tev-Tropin, Accretropin)

Urgent Non-urgent

*This medication must be dispensed at a participating Specialty Pharmacy

***No prior authorization required for Norditropin when prescribed by a pediatric endocrinologist.**

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Drug Requested (please choose one):

Norditropin: 5 mg FlexPro pen 10mg FlexPro pen
 15 mg FlexPro pen 30mg Nordiflex pen

Please note: Norditropin is the preferred product, so if criteria is met for human growth hormone, a therapeutic trial and clinical failure of a preferred product is required prior to a non-preferred product being authorized. No prior authorization required for Norditropin when prescribed by a pediatric endocrinologist.

Nutropin: 10 mg vial 5 mg vial

Nutropin AQ: 10 mg vial 10mg cartridge 20mg cartridge
 5 mg NuSpin cartridge 10 mg NuSpin cartridge 20mg NuSpin cartridge

Genotropin: 0.2mg miniquick 0.4mg miniquick 0.6mg miniquick 0.8mg miniquick
 1mg miniquick 1.2mg miniquick 1.4mg miniquick 1.6mg miniquick
 1.8mg miniquick 2mg miniquick 5.8mg cartridge 13.8mg cartridge

Humatrope: 5mg cartridge 6mg cartridge 12mg cartridge 24mg cartridge

Omnitrope: 1.5mg vial 5.8mg vial 5mg/ml inj

Saizen : 5mg vial 8.8mg vial 5mg powder 8.8mg powder

Tev-Tropin: 5mg vial

Accretropin: 5mg/ml vial 5mg/ml cartridge

Priority Health Precertification Requirements:

Authorization of human growth hormone requires:

- Must be prescribed by a pediatric endocrinologist or pediatric nephrologist
- **Indications for children**
 1. Growth hormone deficiency
 - Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of < 10th % for bone age and gender
 - Height is less than the 5th % for age/sex
 - Growth plates must be open
 - Bone age must be a minimum of 1 year behind chronological age (unless GHD 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
 2. Turner's syndrome
 - Height is less than 10th %
 - Growth plates must be open
 3. Pre-transplant chronic renal insufficiency
 - Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of < 10th % for bone age and gender
 - Height is less than the 5th % for age/sex
 - Growth plates must be open
 - Patient is receiving weekly dialysis or SCR < 2 mg/dL
 4. Prader-Willi Syndrome
 - submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of < 10th % for bone age and gender
 - Growth plates must be open
 - Documented decreased muscle tone by exam
 5. Neonatal Hypoglycemia associated with growth hormone deficiency
 - Growth plates must be open
 - Bone age must be a minimum of 1 year behind chronological age (unless GHD 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
- Benefit exclusions for children
 - Constitutional growth delay
 - Patients with acute or chronic catabolic illness
- Continuation criteria (up to 12 months)
 - First 12 months of therapy: ≥ 7.0 cm/year
 - > 12 months of therapy: ≥ 6 cm/year
 - Bone age: Girls > 13 years, ≥ 2.5 cm/year; Boys 15 years, ≥ 2.5 cm/year
 - If not on maximum recommended dose
- Duration of therapy (whichever comes first)
 - Growth velocity is less than 2.5 cm/year
 - Bone age in males reaches 16
 - Bone age in females reaches 14

- **Growth Hormone Replacement in adults at least 18 years**
 - Documented growth hormone deficiency by: suboptimal response (< 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
 - 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
 - Adults treated during childhood without documented evidence of persistent GH deficiency
 - Physiologic reductions in GH related to aging
 - Treatment of Turner's syndrome or cystinosis
 - Duration of therapy for adults is 1 year

Please Complete the Following Information:

If requesting a non-preferred product, patient has had a documented therapeutic trial and clinical failure of preferred product (Norditropin):

Yes
 Drug: _____ Trial dates: _____
 Drug: _____ Trial dates: _____

No – Rationale for use: _____

Pediatrics

New request or continuation of therapy:

- New request
- Continuation of therapy (see continuation section)

Patient has at least one of the following conditions/contraindications (please check all that apply):

- Yes – Rationale for use: _____
 - Constitutional growth delay
 - Acute or chronic catabolic illness
- No

Pediatric Diagnoses:

 1. Growth hormone deficiency

All of the following apply (please check all that apply):

 Yes

- An untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of < 10th % for bone age and gender has been submitted
- Height is less than the 5th % for age/sex
- Growth plates must be open
- Bone age must be a minimum of 1 year behind chronological age (unless GHD 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

No – Rationale for use: _____

 2. Turner's syndrome

All of the following apply (please check all that apply):

 Yes

- Height is less than the 10^h % for age/sex
- Growth plates must be open

No – Rationale for use: _____

 3. Pre-transplant chronic renal insufficiency

All of the following apply (please check all that apply):

 Yes

- Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of < 10th % for bone age and gender
- Height is less than the 5th % for age/sex
- Growth plates must be open
- Patient is receiving weekly dialysis or SCR < 2 mg/dL

No – Rationale for use: _____

4. Prader-Willi Syndrome

All of the following apply (please check all that apply):

- Yes
- Must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of $< 10^{\text{th}}$ % for bone age and gender
 - Growth plates must be open
 - Documented decreased muscle tone by exam
- No – Rationale for use: _____
- _____
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5. Neonatal Hypoglycemia associated with growth hormone deficiency

All of the following apply (please check all that apply):

- Yes
- Growth plates must be open
 - Bone age must be a minimum of 1 year behind chronological age (unless GHD 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
- No – Rationale for use: _____
- _____
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Pediatric Continuation Section

Length of time patient has been on human growth hormone therapy: _____

Patient's bone age: _____

Patient's gender:

- Male
 Female

Current growth velocity: _____ cm/year

Adults – For adults age 18 and older

- Documented growth hormone deficiency by (check which applies):
- Suboptimal response (< 3 mcg/l) to a hypoglycemic challenge
 - If hypoglycemic challenge is contraindicated, can use other accepted method:
Please describe other method: _____
- At least 2 other pituitary-related hormone deficiencies and an abnormally low IGF
- At least **one** of the following applies (please check all that apply):
- Yes
 - 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
 - No – Rationale for use: _____

Patient has at least one of the following conditions/contraindications (please check all that apply):

- Yes – Rationale for use: _____
- Adults treated during childhood without documented evidence of persistent GH deficiency
 - Physiologic reductions in GH related to aging
 - Treatment of Turner's syndrome or cystinosis
- No

***** All fields must be complete and legible for Prior Authorization Review*****
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX