Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**

This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Human Growth Hormone

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Drug information

☐ New request ☐ Continuation request

☐ Genotropin
☐ Genotropin Miniquick
☐ Humatrope
☐ Humatrope Combo Pack
☐ Zorbtive
☐ Norditropin Flexpro
☐ Nutropin AQ
☐ Nutropin AQ Nuspin
☐ Serostim

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Drug strength requested: _____

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 11/2017
Last reviewed 11/2017

Patient must meet the following requirements:

- Must be prescribed by an endocrinologist, gastroenterologist, or nephrologist
- **Indications for children**
  1. Growth hormone deficiency
     - Height is less than the fifth percentile for age and gender
     - Submit untreated growth velocity curve with 1 year of growth data showing a growth velocity of less than tenth-percentile for bone age and gender
     - Growth plates must be open
     - Bone age must be 1 or more years behind chronological age unless growth hormone deficiency is related to pituitary surgery, radiation therapy, or with precocious puberty
     - Must have a documented growth hormone deficiency by:
       1. 2 growth hormone stimulation tests below 10 ng/mL
       2. ***–or–*** growth hormone stimulation test level less than 15 ng/mL, as well as IGF-1 and IGF-PB3 levels below normal for bone age and gender
     - 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 fifth-percentile for age and gender
     - Patient is receiving weekly dialysis or serum creatinine is less than 2 mg/dL
     - Submit untreated growth velocity curve with 1 year of growth data showing a growth velocity of less than tenth-percentile for bone age and gender
     - Growth plates must be open
     - Bone age must be a 1 or more years behind chronological age unless growth hormone deficiency is related to pituitary surgery, radiation therapy, or with precocious puberty
     - Must have a documented growth hormone deficiency by:
       1. 2 growth hormone stimulation tests below 10 ng/mL
       2. ***–or–*** growth hormone stimulation test level less than 15 ng/mL, as well as IGF-1 and IGF-PB3 levels below normal for bone age and gender

  The following conditions are not covered 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:
       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
  2. For the drug Zorbtive, patient must only have a diagnosis of short bowel syndrome

  The following conditions are not covered 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

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Updated 11/2017
Last reviewed 11/2017

Priority Health Precertification Documentation
FOR CHILDREN

A. What is the patient's diagnosis?

☐ Growth hormone deficiency
- ☐ Height is less than the 5th percentile for age/sex

☐ Turner's syndrome
- ☐ Height is less than 10th percentile

☐ Pre-transplant chronic renal insufficiency
- ☐ Height is less than the 5th percentile for age/sex

and one of the following:
- ☐ Patient is receiving weekly dialysis
- ☐ Serum creatinine is less than 2 mg/dL

☐ *Other – the patient's condition is:* _____

B. ☐ Submit untreated growth velocity curve with a 1 year of growth data showing a growth velocity of less than tenth-percentile for bone age and gender

C. Are the patient's growth plates open?

☐ Yes ☐ No

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

☐ Yes ☐ No

Is the patient's hormone deficiency is related to:
- ☐ pituitary surgery,
- ☐ radiation therapy, or
- ☐ precocious puberty
- ☐ None of the above

E. The following documentation showing growth hormone deficiency is attached:

☐ 2 growth hormone stimulation tests below 10 ng/mL
☐ Growth hormone stimulation test level less than 15 ng/mL as well as IGF-1 and IGF-PB3 levels below normal bone age and gender
☐ None of the above attached

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

☐ Yes ☐ No

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Updated 11/2017
Last reviewed 11/2017

PriorityHealth

FOR ADULTS AGE 18 AND OLDER

A. What is the patient's diagnosis?

- ☐ Growth hormone deficiency
  GH deficiency is documented by which of the following?
  - ☐ suboptimal response (less than 3 mcg/L) to a hypoglycemic challenge ***–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
- ☐ Short Bowel Syndrome
- ☐ *Other – the patient's condition is:* _____

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would human growth hormone likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using human growth hormone, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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Updated 11/2017
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