



Growth Hormone Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDF](https://magellanrx.com/member/external/commercial/common/doc/en-us/phi_disclosure_authorization.pdf)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES: **ICD-10:**

<input type="checkbox"/> Growth hormone deficiencies WITHOUT organic pituitary disease <input type="checkbox"/> Growth hormone deficiencies WITH organic pituitary disease <input type="checkbox"/> Idiopathic Short Stature (ISS) <input type="checkbox"/> Small for gestation age (SGA) <input type="checkbox"/> Turner's Syndrome <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Noonan Syndrome <input type="checkbox"/> Short Stature Homeobox (SHOX) Syndrome	
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3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

FOR ALL REQUESTS:
 Has the patient tried Norditropin for at least 3 months and had an inadequate response or intolerance (unless requesting Nordotropeq)? Yes No

PEDIATRIC PATIENTS <18 YEARS OF AGE:
 Is the provider a pediatric endocrinologist or in the case of chronic kidney disease, pediatric nephrologist? Yes No

For GHD WITHOUT organic pituitary disease:
 Does the patient have growth failure caused by inadequate secretion of endogenous growth hormone in the absence of organic pituitary disease? Yes No

Has growth hormone deficiency been confirmed by ONE of the following:
 TWO provocative test with results below 10 ng/ml (i.e. i.e., L-Dopa, insulin-induced hypoglycemia, arginine, glucagon, or clonidine)
 ONE provocative stimulation test less than 15 ng/mL AND a low insulin-like growth factor-1 (IGF-1) level for the patients age, gender, and pubertal status AND a low IGFBP (insulin-like growth factor binding protein-3)
Documentation must be submitted

Is the patient's height below the third percentile for their age and gender related height? Yes No
Documentation must be submitted

Does the patient have a decreased growth velocity of ≥ 2 standard deviations (SD) below the age-related mean measured over 1 year? Yes No
Documentation must be submitted

Does the patient have delayed skeletal maturation of ≥ 2 SD below the age/gender related mean? Yes No
Documentation must be submitted





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In patient's ≥ 10 years of age, are the epiphyses confirmed as open? Yes No

Documentation must be submitted

For GHD WITH organic pituitary disease:

Does the patient have a diagnosis of GHD caused by an inadequate secretion of endogenous growth hormone in the presence of 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)? Yes No

Is the serum IGF-1 level lower than the age-specific lower limit of normal? Yes No

Documentation must be submitted

Does the MRI or CT of head show pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, and/or ectopic posterior pituitary "bright spot"? Yes No *Documentation must be submitted*

For idiopathic short stature (ISS):

Does the patient have a diagnosis of non growth hormone deficient short stature? Yes No

Is the patient's height standard deviation score (SDS) of 2.25 or below the mean chronological age and sex?

Yes No *Documentation must be submitted*

Have other causes such as genetic, metabolic, or organ system dysfunction been ruled out and documented?

Yes No *Documentation must be submitted*

For chronic kidney disease:

Has the patient received a renal transplant? Yes No

Is the patient's height below the 3rd percentile for their age and gender related height? Yes No

Documentation must be submitted

Small for Gestational Age (SAG):

Was the patient born small for gestational age (SGA), defined as birth weight and/or birth length two or more SDs below the mean for gestational age? Yes No

Documentation must be submitted

Has the patient failed to catch up in growth by 2-4 years of age, defined as two or more SDs below the mean in birth weight and/or birth height for age and sex? Yes No

Documentation must be submitted

Does the patient have another clinically defined syndrome known to cause short stature due to primary growth failure(per ICPED), including Down Syndrome (Trisomy 21) and Silver-Russell syndrome? Yes No

Documentation must be submitted

Does the patient have congenital bone dysplasia, including achondroplasia and hypochondroplasia? Yes No

Documentation must be submitted





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For Turner's syndrome:

Was the patient's diagnosis confirmed by chromosome analysis? Yes No

Documentation must be submitted

Does the patient's height fall below the 5th percentile for chronological age and sex? Yes No

Documentation must be submitted

For Prader-Willi Syndrome: Was the diagnosis confirmed by genetic testing (loss of gene function associated with chromosome 15 such as translocation or maternal uniparental disomy)? Yes No

Documentation must be submitted

Has an assessment of underlying airway obstruction including sleep studies been completed? Yes No

Documentation must be submitted

Does the patient have any of the following:

- severe obesity
- history of upper airway obstruction
- respiratory compromise
- severe sleep apnea

For Short Stature Homeobox (SHOX) deficiencies: Was the diagnosis confirmed via chromosomes analysis?

Yes No

For ADULT patients ≥ 18 years of age:

Does the patient have adult onset GHD alone or with multiple hormone deficiencies (such as hypopituitarism), as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma? Yes No

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? Yes No

Documentation must be submitted

Does that patient have a subnormal GH response to insulin-induced hypoglycemia (<5.1 ng/mL) or arginine-GHRH (<4.1ng/mL)? Yes No

Documentation must be submitted

For Adults with childhood-onset GHD:

Does the patient have childhood-onset GHD as a result of congenital, acquired, or idiopathic causes? Yes No

Has the patient been retested at least 1 month after GH therapy has been discontinued and final height has been achieved and subnormal responses to at least one standard GH stimulation test confirm need for GH therapy?

Yes No





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For GHD with organic pituitary disease:

Does the patient have organic pituitary disease (e.i. 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)? Yes No

Documentation must be submitted

Does the patient have past OR current IGF-1 levels that are below the age- and sex-appropriate reference range without GH therapy? Yes No

Documentation must be submitted

Has the patient had a subnormal GH response to insulin-induced hypoglycemia hypoglycemia (<5.1ng/ml) or arginine-GHRH (<4.1ng/ml)? Yes No

ZORBTIVE only: Does the patient have a diagnosis of short bowel syndrome as a result of resected or damaged bowel? Yes No

Does the patient have any of the following symptoms:

- chronic diarrhea
- weight loss
- electrolyte imbalances
- malnutrition
- dehydration
- malabsorption of fats, vitamins and minerals

Is the patient receiving specialized nutritional support (i.e. parenteral nutrition or enteral feedings)? Yes No

Documentation must be submitted

REAUTHORIZATION

Pediatric patients < 18 years of age:

Does the patient have one of the following diagnosis:

- 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
- chronic kidney disease

Are the patient's epiphyses open? Yes No

If the patient is male with a bone age of up to 16 years of age, is the patient's growth response at least 4.5 cm/year (prepubertal growth rate) or at least 2.5 cm/yr (post-puberty growth rate)? Yes No

If the patient is female with a bone age of up to 14 years, is the patient's growth response at least 4.5 cm/yr (prepubertal growth rate) or at least 2.5 cm/yr (post-puberty growth rate)? Yes No





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For a diagnosis of Prader-Willi syndrome:

Has the patient experienced an increase in lean body mass, decrease in fat, or maintenance of benefit? Yes No

Adults (≥ 18 years of age): Has the patient experienced clinical benefit while on therap (ie increase in total lean body mass, increase IGF-1 and IGFBP3 levels, or increase in exercise capacity)? Yes No

ZORBITIVE renewal: Has the patient experienced clinical benefit while on therapy (i.e. decrease in intravenous nutrition requirements)? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street, Phoenix, AZ 85034
Phone: 877-228-7909

