

# GROWTH HORMONE

(Humatrope, Norditropin, Genotropin, Nutropin, Omnitrope, Saizen, Tev-Tropin)

## Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

### PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> Brand <input type="checkbox"/> Generic			
Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.			
<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing, provide date started:	Anticipated duration of use?	
Please indicate place of administration: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic <input type="checkbox"/> Patient Home	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient		
Please provide hospital/facility name and address:			

### Please provide the following information for ALL requests:

Present height (include units): _____	Percentile: _____	Standard Deviation Score: _____
Pretreatment growth velocity (initial requests): _____		Growth velocity on treatment: _____
Recent skeletal bone age (please submit chart documentation): _____		
Has the member had evidence of active malignancy within the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have active proliferative or severe non-proliferative diabetic retinopathy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Diagnosis (Please Check One):</b> (To allow for complete review, please provide CHART DOCUMENTATION as described below.)		
<input type="checkbox"/> <b>Child or adolescent with classic Growth Hormone Deficiency</b> (Chart documentation should include: diagnosis, growth chart, results of 2 provocative growth hormone stimulation tests, pretreatment growth velocity, comparison of skeletal (bone) age compared to chronological age, treatment plan)		
Please provide names and dates of specific growth hormone stimulation tests:		
Does the member have a history of irradiation or multiple pituitary hormone deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> <b>Child with growth retardation due to Chronic Renal Insufficiency and awaiting kidney transplantation</b> (Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan)		
Anticipated date of renal transplant:		
<input type="checkbox"/> <b>Female child with Turner's Syndrome/Noonan Syndrome</b> (Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan)		
<input type="checkbox"/> <b>Child with Prader-Willi Syndrome</b> (Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan)		
Please provide the member's BMI: _____		
Does the member have severe respiratory impairment or a history of upper airway obstruction or sleep apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please be sure to complete the 2<sup>nd</sup> page of this form.

# GROWTH HORMONE

Page 2

Patient name:

Patient UPMC Health Plan ID Number:

Patient DOB:

Please be sure to complete and include this page with the 1<sup>st</sup> page of this form.

**Child with Short Stature Homeobox-containing Gene (SHOX) deficiency** (Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, comparison of skeletal (bone) age compared to chronological age, and treatment plan.)

**Child born Small for Gestational Age (SGA)** (Chart documentation should include diagnosis, birth weight and length, gestational age, growth chart, pretreatment growth velocity, treatment plan)

Gestational age: \_\_\_\_\_

Birth weight: \_\_\_\_\_

Birth length: \_\_\_\_\_

Height or weight percentile or standard deviation at birth: \_\_\_\_\_

**Adult with Growth Hormone Deficiency with childhood onset** (Chart documentation should include: diagnosis, diagnosis as a child, results of reassessment of provocative growth hormone stimulation test using the insulin tolerance test unless contraindicated, documentation explaining if patient has reached adult peak bone mass, treatment plan)

OR

**Adult with Growth Hormone Deficiency with adult onset** (Chart documentation should include: underlying cause of Growth Hormone Deficiency, if underlying cause is unknown - evidence of hypothalamic pituitary disease, documentation of at least one other hormone deficiency (other than GH) such as TSH, ACTH, or gonadotropins (except for prolactin), results of provocative growth hormone stimulation test using the insulin tolerance test, if the member has diabetes – documentation that their diabetes is controlled and that the patient does not have diabetes with unstable proliferative retinopathy, treatment plan)

Please indicate cause of growth hormone deficiency (if applicable):

Has the member been off growth hormone for at least 1 month (for adult with childhood onset)?

Yes  No

Serum IGF-I level while NOT on growth hormone (if applicable):

Please indicate if the member has any of the following (and submit chart documentation to support):

Severe growth hormone deficiency in childhood due to genetic cause

Severe growth hormone deficiency and receipt of high-dose cranial radiation therapy

Structural hypothalamic-pituitary disease

Central nervous system tumor(s)

Deficiencies in the following pituitary hormones:

Adrenocorticotropin hormone (ACTH)

Arginine vasopression (VAP)

Thyroid stimulating hormone (TSH)

Gonadotropins [leutinizing hormone (LH) and follicle stimulating hormone (FSH)]

Prolactin

Please provide names and dates of specific growth hormone stimulation tests (if applicable):

Does the member have a pituitary adenoma?

Yes  No

If yes, has the tumor size remained stable for 1 year?

Yes  No

**Other** (Please provide specific chart documentation describing underlying condition and rationale for growth hormone treatment.)

Patient Medical Chart Information Sent?

Yes  No