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: ☐**Brand** ☐**Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

☐**New Medication** ☐**Ongoing Medication**	**If Ongoing, provide date started:**	**Anticipated duration of use?**

Please indicate place of administration:
☐ Physician's Office
☐ Hospital/Clinic
☐ Patient Home

Please provide hospital/facility name and address:

Will the drug be: (select one)
☐ Billed directly by the provider via JCODE
JCODE: _____
☐ Billed by a pharmacy and delivered to the provider
☐ Billed by a pharmacy and delivered to the patient

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? ☐ Yes ☐No

Does the member have active proliferative or severe non-proliferative diabetic retinopathy? ☐ Yes ☐No

Diagnosis (Please Check One): *(To allow for complete review, please provide CHART DOCUMENTATION as described below.)*

☐**Child or adolescent with classic Growth Hormone Deficiency** *(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? ☐ Yes ☐No

☐**Child with growth retardation due to Chronic Renal Insufficiency and awaiting kidney transplantation** *(Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan)*

Anticipated date of renal transplant:

☐**Female child with Turner's Syndrome/Noonan Syndrome** *(Chart documentation should include: diagnosis, growth chart, pretreatment growth velocity, and treatment plan)*

☐**Child with Prader-Willi Syndrome** *(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? ☐**Yes** ☐ No

Please be sure to complete the 2nd page of this form.

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Patient name:	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include this page with the 1st 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)
- ☐ Thyroid stimulating hormone (TSH)
- ☐ Prolactin
- ☐ Arginine vasopression (VAP)
- ☐ Gonadotropins [leutinizing hormone (LH) and follicle stimulating hormone (FSH)]

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