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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

**Patient Name:** \_\_\_\_\_ **Date:** 6/19/2025  
**Patient ID:** \_\_\_\_\_ **Patient Date Of Birth:** \_\_\_\_\_  
**Patient Group No:** \_\_\_\_\_ **Patient Phone:** \_\_\_\_\_ **Physician Name:** \_\_\_\_\_  
**NPI#:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_  
**Physician Office Address:** \_\_\_\_\_  
**Drug Name (specify drug):** \_\_\_\_\_  
**Quantity:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_ **Strength:** \_\_\_\_\_  
**Route of Administration:** \_\_\_\_\_ **Expected Length of Therapy:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_  
**Comments:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check the appropriate answer for each applicable question.**

1. What is the diagnosis?
 

Pediatric growth hormone deficiency (including panhypopituitarism) (If checked, go to 2)  
 Other, please specify. (If checked, no further questions)  
 \_\_\_\_\_

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2. Is the request for continuation of therapy of the requested drug, or another growth hormone product indicated for pediatric growth hormone (GH) deficiency?
 

**Y** ☐      **N** ☐
3. Is the patient currently receiving growth hormone through samples or a manufacturer's patient assistance program?
 

Yes (If checked, go to 13)  
 No (If checked, go to 4)  
 Unknown (If checked, go to 13)

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4. Has the patient been previously approved for prior authorization for growth hormone under a health plan or pharmacy benefit manager?
 

**Y** ☐      **N** ☐
5. Is the following information provided by the prescriber: A) Total duration of treatment (approximate duration is acceptable), B) Date of the last dose administered, C) Approving health plan/pharmacy benefit manager, D) Date of the prior authorization/approval, and e) Prior authorization approval letter? **ACTION REQUIRED:** If Yes, attach medical records. **ACTION REQUIRED:** Submit supporting documentation
 

**Y** ☐      **N** ☐
6. Is information on the patient's current age provided? Indicate age in years and months.
 

\_\_\_\_\_  
 \_\_\_\_\_

**Y** ☐      **N** ☐
7. Is information on the patient's current height provided? Indicate height in centimeters.
 

\_\_\_\_\_  
 \_\_\_\_\_

**Y** ☐      **N** ☐
8. Is information on the date growth hormone therapy was initiated provided?
 

\_\_\_\_\_  
 \_\_\_\_\_

**Y** ☐      **N** ☐
9. Are the epiphyses still open?
 

Yes, confirmed by X-ray (If checked, go to 10)  
 Yes, but X-ray not available (If checked, go to 10)

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|                                                                                                                                                                                                                                                                                                                                                                                             |   |                          |                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|--------------------------|----------------------------|
| No (If checked, no further questions)                                                                                                                                                                                                                                                                                                                                                       |   | <input type="checkbox"/> |                            |
| 10. Is the patient growing at a rate of more than 2 cm/year? ACTION REQUIRED: If Yes, attach current growth chart showing growth velocity.<br>ACTION REQUIRED: Submit supporting documentation                                                                                                                                                                                              | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 11. Is there a clinical reason for the lack of efficacy?                                                                                                                                                                                                                                                                                                                                    | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 12. What is the clinical reason for the lack of efficacy?<br>On treatment less than 1 year - Indicate treatment duration (If checked, no further questions)                                                                                                                                                                                                                                 |   | <input type="checkbox"/> |                            |
| _____                                                                                                                                                                                                                                                                                                                                                                                       |   | <input type="checkbox"/> |                            |
| Nearing final adult height or in later stages of puberty (If checked, no further questions)                                                                                                                                                                                                                                                                                                 |   | <input type="checkbox"/> |                            |
| Other, please specify. (If checked, no further questions)                                                                                                                                                                                                                                                                                                                                   |   | <input type="checkbox"/> |                            |
| _____                                                                                                                                                                                                                                                                                                                                                                                       |   |                          |                            |
| 13. Is the patient 3 years of age or older?                                                                                                                                                                                                                                                                                                                                                 | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 14. Was the patient diagnosed with growth hormone (GH) deficiency as a neonate?                                                                                                                                                                                                                                                                                                             | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 15. Is there documentation to support the diagnosis of neonatal growth hormone (GH) deficiency (such as hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiencies, magnetic resonance imaging [MRI] results)? ACTION REQUIRED: If Yes, attach medical documentation, laboratory report, or imaging report.<br>ACTION REQUIRED: Submit supporting documentation | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 16. Is the documentation supporting the diagnosis of neonatal growth hormone (GH) deficiency (such as hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiencies, magnetic resonance imaging [MRI] results) attached?                                                                                                                                           | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 17. Does the patient have 2 pretreatment pharmacologic provocative tests for growth hormone (GH)? ACTION REQUIRED: If Yes, attach laboratory report or medical record of pre-treatment provocative test results.<br>ACTION REQUIRED: Submit supporting documentation                                                                                                                        | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 18. What is the peak level? Indicate in ng/mL.<br>Less than 10 ng/mL (If checked, go to 22)                                                                                                                                                                                                                                                                                                 |   | <input type="checkbox"/> |                            |
| _____                                                                                                                                                                                                                                                                                                                                                                                       |   | <input type="checkbox"/> |                            |
| Greater than or equal to 10 ng/mL (If checked, go to 19)                                                                                                                                                                                                                                                                                                                                    |   | <input type="checkbox"/> |                            |
| _____                                                                                                                                                                                                                                                                                                                                                                                       |   |                          |                            |
| 19. Does the patient have a pituitary or central nervous system (CNS) disorder?                                                                                                                                                                                                                                                                                                             | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 20. What is the pituitary or central nervous system (CNS) disorder?                                                                                                                                                                                                                                                                                                                         |   |                          |                            |
| Transcription factor defect (PIT-1, PROP-1, LHX3/4, HESX-1, PITX-2) (If checked, go to 21)                                                                                                                                                                                                                                                                                                  |   | <input type="checkbox"/> |                            |
| Growth hormone releasing hormone (GHRH) receptor gene defect (If checked, go to 21)                                                                                                                                                                                                                                                                                                         |   | <input type="checkbox"/> |                            |
| GH secretagogue receptor gene defect (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                 |   | <input type="checkbox"/> |                            |
| GH gene defect (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                                       |   | <input type="checkbox"/> |                            |
| Optic nerve hypoplasia/septo-optic dysplasia (If checked, go to 21)                                                                                                                                                                                                                                                                                                                         |   | <input type="checkbox"/> |                            |
| Agenesis of corpus callosum (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                          |   | <input type="checkbox"/> |                            |
| Empty sella syndrome (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                                 |   | <input type="checkbox"/> |                            |
| Ectopic posterior pituitary (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                          |   | <input type="checkbox"/> |                            |
| Pituitary aplasia/hypoplasia (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                         |   | <input type="checkbox"/> |                            |
| Pituitary stalk defect (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                               |   | <input type="checkbox"/> |                            |
| Holoprosencephaly (If checked, go to 21)                                                                                                                                                                                                                                                                                                                                                    |   | <input type="checkbox"/> |                            |

- Encephalocele (If checked, go to 21) ☐
- Hydrocephalus (If checked, go to 21) ☐
- Anencephaly or prosencephaly (If checked, go to 21) ☐
- Arachnoid cyst (If checked, go to 21) ☐
- Other mid-line facial defects (e.g., single central incisor, cleft lip/palate) (If checked, go to 21) ☐
- Vascular malformation (If checked, go to 21) ☐
- CNS tumor/neoplasm (e.g., craniopharyngioma, glioma/astrocytoma, pituitary adenoma, germinoma) (If checked, go to 21) ☐
- Cyst (Rathke cleft cyst or arachnoid cleft cyst) (If checked, go to 21) ☐
- Surgery (If checked, go to 21) ☐
- Radiation (If checked, go to 21) ☐
- Chemotherapy (If checked, go to 21) ☐
- CNS infection (If checked, go to 21) ☐
- CNS infarction (If checked, go to 21) ☐
- Inflammatory process (e.g., autoimmune hypophysitis) (If checked, go to 21) ☐
- Infiltrative process (e.g., sarcoidosis, histiocytosis, hemochromatosis) (If checked, go to 21) ☐
- Head trauma/traumatic brain injury (If checked, go to 21) ☐
- Aneurysmal subarachnoid hemorrhage (If checked, go to 21) ☐
- Perinatal or postnatal trauma (If checked, go to 21) ☐
- Surgery of the pituitary or hypothalamus (If checked, go to 21) ☐
- Other, please specify. (If checked, no further questions) ☐

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21. Does the patient have a pretreatment insulin-like growth factor-1 (IGF-1) level greater than 2 standard deviations (SD) below the mean based on the laboratory reference range? ACTION REQUIRED: If Yes, attach laboratory report or medical record of pretreatment IGF-1 level. Y ☐ N ☐  
ACTION REQUIRED: Submit supporting documentation
22. Is one pretreatment height and the patient's age at the time the height was recorded provided? Indicate height in centimeters and age in years and months. Y ☐ N ☐
- 
23. Is a second pretreatment height and the patient's age at the time the height was recorded provided? Indicate height in centimeters and age in years and months. Y ☐ N ☐
- 
24. Does the patient have a pretreatment height of greater than 2 standard deviations (SD) below the mean for age and gender? ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment height. Y ☐ N ☐  
ACTION REQUIRED: Submit supporting documentation
25. Does the patient have a pretreatment 1-year height velocity of greater than 1 standard deviation (SD) below the mean for age and gender? ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment height and height velocity. Y ☐ N ☐  
ACTION REQUIRED: Submit supporting documentation
26. Does the patient have a pretreatment 1-year height velocity of greater than 2 standard deviations (SD) below the mean for age and gender? ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment height velocity. Y ☐ N ☐  
ACTION REQUIRED: Submit supporting documentation
27. Are the epiphyses still open? Y ☐ N ☐
28. Are the laboratory reports or medical record documentation of the pretreatment provocative tests for growth hormone (GH), pretreatment insulin-like growth factor-1 (IGF-1) levels, and growth chart attached, if applicable? Y ☐ N ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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**Prescriber (Or Authorized) Signature and Date**

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