Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

{{PANUMCODE}}

{{DISPLAY_PAGNAME}}
{{PACDESCRIPTION}}

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to {{COMPANY_NAME}} at {{CLIENT_PAG_FAX}}. Please contact {{COMPANY_NAME}} at {{CLIENT_PAG_PHONE}} with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of {{DRUGNAME}}.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}} **Patient Phone:** <<MEMPHONE>>
Specialty: _____ **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Physician Office Address: <<PHYADDRESS1>> <<PHYADDRESS2>> <<PHYCITY>>, <<PHYSTATE>> <<PHYZIP>>
Drug Name: {{DRUGNAME}}

Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: <<DIAGNOSIS>> **ICD Code**: <<ICD9>>

1. What drug is being prescribed?
   ❑ Genotropin ***(preferred)*** ❑ Nutropin AQ ❑ Humatrope ❑ Saizen
   ❑ Norditropin ***(preferred)*** ❑ Zomacton ❑ Omnitrope ❑ Other _____

2. What is the diagnosis?
   ❑ Small for gestational age (SGA)
   ❑ Growth failure associated with cerebral palsy
   ❑ Growth failure associated with cystic fibrosis
   ❑ HIV-associated wasting/cachexia
   ❑ Growth failure associated with chronic kidney disease (CKD)
   ❑ Idiopathic short stature (ISS)
   ❑ Short bowel syndrome (SBS)
   ❑ Prader-Willi syndrome
   ❑ Noonan syndrome
   ❑ Turner syndrome
   ❑ Pediatric growth hormone deficiency (GH) (including panhypopituitarism)
   ❑ Adult growth hormone deficiency (GH) (including panhypopituitarism)
   ❑ Growth failure associated with congenital adrenal hyperplasia
   ❑ Growth failure associated with Russell-Silver syndrome
   ❑ Short stature homeobox-containing gene (SHOX) deficiency
   ❑ Other _____

3. What is the ICD-10 code? _____

4. Is this request for continuation of therapy? ❑ Yes ❑ No *If No, skip to diagnosis section.*

5. Is the patient currently receiving growth hormone through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown

6. Please indicate/attach the following information provided by the prescriber. ***ACTION REQUIRED: Attach medical records.***
   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: _____
   E) **Attach** authorization approval letter

Complete the following section based on patient's diagnosis, if applicable.

Section A: Short Bowel Syndrome

1 Is the patient dependent on intravenous parenteral nutrition (e.g. TPN) for nutritional support? ❑ Yes ❑ No

2. Will the requested product be used in conjunction with optimal management of short bowel syndrome (SBS)?
   ❑ Yes ❑ No

3. How many weeks of growth hormone (GH) therapy has the patient received in their lifetime? _____ weeks

Section B: Pediatric Disorders *Please complete the following sub-section, if applicable.*

1. Please indicate the date GH deficiency was diagnosed and the date GH therapy was initiated (if applicable).
   Date of diagnosis: _____ Date GH therapy was initiated: _____

2. Indicate patient's **pretreatment** height and age ***(two measurements taken 6-18 months apart)***:
   ACTION REQUIRED: Attach a growth chart showing pretreatment heights and growth velocity.
   a) Height: _____ cm Age: _____ years, _____ months Date: _____
   b) Height: _____ cm Age: _____ years, _____ months Date: _____

3. Has patient had any **pretreatment** pharmacologic provocative tests? ***ACTION REQUIRED: If Yes, attach laboratory report or medical record of pre-treatment provocative test results.***
   ❑ Yes, ***How many?*** _____ ❑ No
   ❑ Agent: _____ Peak Level: _____ ng/mL Date: _____
   ❑ Agent: _____ Peak Level: _____ ng/mL Date: _____

4. What is the **pretreatment** 1-year height velocity? ***ACTION REQUIRED: Attach a growth chart showing growth velocity.*** _____ cm/year

5. Does the patient have a **pretreatment** slow growth velocity? ***ACTION REQUIRED: Attach a growth chart showing growth velocity.*** ❑ Yes ❑ No

6. *If the patient's pre-treatment age is less than 2.5 years of age*, does the patient have a pretreatment height of greater than 2 standard deviations (SD) below the mean for age and gender AND a slow growth velocity? ***ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment heights and growth velocity and no further questions.*** ❑ Yes ❑ No ❑ N/A - pretreatment age is greater than or equal to 2.5 years of age

7. 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.*** ❑ Yes ❑ No

8. Are the epiphyses still open? ❑ Yes, confirmed by X-ray ❑ Yes, but X-ray is not available ❑ No

9. Indicate patient's **current**: Height: _____ cm Age: _____ years, _____ months

10. *If currently on therapy*, is the patient growing at a rate of more than 2 cm/year? ***ACTION REQUIRED: If Yes, collect current growth chart showing growth velocity.*** ❑ Yes ❑ No
    Indicate therapy start date:_____

11. What is the clinical reason for the lack of efficacy?
    ❑ On treatment less than 1 year - Indicate treatment duration: _____
    ❑ Nearing final adult height/in later stages of puberty
    ❑ Other _____

I. Pediatric GHD (includes panhypopituitarism)

1. Is the patient a neonate or was the patient diagnosed with growth hormone (GH) deficiency as a neonate?
   ❑ Yes ❑ No *If No, skip to #3*

2. Are medical records available 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, or chart notes? ***ACTION REQUIRED: If Yes, attach medical records.***
   ❑ Yes ❑ No

3. What is the pituitary or central nervous system (CNS) disorder? *List continues on next page.*
   ❑ GH secretagogue receptor gene defect
   ❑ GH gene defect
   ❑ Optic nerve hypoplasia/septo-optic dysplasia
   ❑ Surgery of the pituitary or hypothalamus
   ❑ Agenesis of corpus callosum
   ❑ Empty sella syndrome

- ❑ Ectopic posterior pituitary
- ❑ Pituitary stalk defect
- ❑ Encephalocele
- ❑ Anencephaly or prosencephaly
- ❑ Vascular malformation
- ❑ Radiation
- ❑ CNS infection
- ❑ Inflammatory process (e.g., autoimmune hypophysitis)
- ❑ Aneurysmal subarachnoid hemorrhage
- ❑ Pituitary aplasia/hypoplasia
- ❑ Holoprosencephaly
- ❑ Hydrocephalus
- ❑ Arachnoid cyst
- ❑ Surgery
- ❑ Chemotherapy
- ❑ CNS infarction
- ❑ Head trauma/traumatic brain injury
- ❑ Perinatal or postnatal trauma
- ❑ Infiltrative process (e.g., sarcoidosis, histiocytosis, hemochromatosis)
- ❑ Transcription factor defect (PIT-1, PROP-1, LHX3/4, HESX-1, PITX-2)
- ❑ Growth hormone releasing hormone (GHRH) receptor gene defect
- ❑ Other mid-line facial defects (e.g., single central incisor, cleft lip/palate)
- ❑ CNS tumor/neoplasm (e.g., craniopharyngioma, glioma/astrocytoma, pituitary adenoma, germinoma)
- ❑ Cysts (Rathke cleft cyst or arachnoid cleft cyst)
- ❑ Other: _____
- ❑ No - None of the above

4. 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.*** ❑ Yes ❑ No
   *Indicate patient's **pretreatment** IGF-1 level:* _____ *Range:* _____

II. Turner Syndrome (TS)

1. Was the diagnosis of Turner syndrome confirmed by karyotyping? ***ACTION REQUIRED: If Yes, attach karyotype study result.*** ❑ Yes ❑ No

2. Does the patient have a pretreatment height less than the 5th percentile for age? ***ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment height.*** ❑ Yes ❑ No

III. SHOX Deficiency

1. Has the diagnosis of SHOX deficiency been confirmed by molecular or genetic analyses? ***ACTION REQUIRED: If Yes, attach molecular/genetic test results.*** ❑ Yes ❑ No

IV. Prader-Willi Syndrome (PWS)

1. Was the diagnosis of Prader-Willi syndrome confirmed by genetic testing demonstrating any of the following: A) Deletion in the chromosomal 15q11.2-q13 region, B) Maternal uniparental disomy in chromosome 15, or C) Imprinting defects, translocations, or inversions involving chromosome 15? ***ACTION REQUIRED: If Yes, attach genetic test result.*** ❑ Yes ❑ No

2. *If currently on therapy,* have body composition and psychomotor function improved or stabilized in response to growth hormone (GH) therapy? ❑ Yes ❑ No ❑ N/A, not currently on therapy

V. Small for Gestational Age (SGA)

1. What was the patient's gestational age at birth? _____ weeks _____ days

2. What was the patient's: Birth Weight? _____ grams AND Birth Length? _____ cm
   ACTION REQUIRED: Attach growth charts showing birth weight and length.

3. Was the birth weight or length greater than or equal to 2 standard deviations (SD) below the mean for gestational age? ***ACTION REQUIRED: If Yes, attach growth charts showing birth weight and length.*** ❑ Yes ❑ No

4. Was the birth weight or length less than the 3rd percentile for gestational age? ***ACTION REQUIRED: If Yes, attach growth charts showing birth weight and length.*** ❑ Yes ❑ No

5. Did the patient fail to manifest catch-up growth by age two as demonstrated by **pretreatment** height greater than 2 standard deviations (SD) below the mean for age and gender? ***ACTION REQUIRED: If Yes, collect growth chart showing pretreatment height.*** ❑ Yes ❑ No

VI. Idiopathic Short Stature (ISS)

1. Does the patient have the following adult height prediction: A) Boys: Less than 5 feet, 3 inches, B) Girls: Less than 4 feet, 11 inches? ❑ Yes ❑ No

2. Has pediatric GH deficiency been ruled out with a provocative growth hormone test with a peak of greater than or equal to 10 ng/mL? ***ACTION REQUIRED: If Yes, attach laboratory report or medical record of pretreatment provocative test result***. ❑ Yes ❑ No

Section C: Adult Growth Hormone Disorder

1. Does the patient have a low pre-treatment insulin-like growth factor-1 (IGF-1) (between 0 to 2 standard deviations below the mean for age and gender based on the laboratory reference range)?
   ACTION REQUIRED: If Yes, attach laboratory report or medical record of pretreatment IGF-1 level.
   ❑ Yes ❑ No

2. Has the patient had at least 2 pre-treatment pharmacologic provocative growth hormone (GH) tests?
   ACTION REQUIRED: If Yes, attach laboratory report or medical record of pre-treatment provocative test results. ❑ Yes ❑ No

3. Has patient had any **pretreatment** pharmacologic provocative tests or a pretreatment test with the agent Macrilen? ***ACTION REQUIRED: If Yes, attach laboratory report or medical record of pre-treatment provocative test results.***
   ❑ Yes, *indicate number(s) and list of pre-treatment provocative test* _____ ❑ No
   ❑ Agent: _____ Peak Level: _____ ng/mL Date: _____
   ❑ Agent: _____ Peak Level: _____ ng/mL Date: _____
   ❑ Agent: _____ Peak Level: _____ ng/mL Date: _____

4. What is the patient's body mass index (BMI)?
   Height: _____ cm Weight: _____ lbs / kg Body mass index (BMI): _____ kg/m^2

5. Does the patient have a high pretest probability (e.g., acquired structural abnormalities) of growth hormone deficiency? ❑ Yes ❑ No

6 Does the patient have organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation)? ❑ Yes ❑ No *If No, skip to #9*

7. Does the patient have documented deficiencies in at least three of the following pituitary hormones?
   ❑ Yes ❑ No *If No, skip to #9*

8. Does the patient have deficiencies of three or more pituitary hormones? *Indicate ALL that apply.*
   ❑ Growth hormone
   ❑ Antidiuretic hormone (ADH)
   ❑ Luteinizing hormone (LH)
   ❑ Prolactin
   ❑ Adrenocorticotropic hormone (ACTH)
   ❑ Follicle stimulating hormone (FSH)
   ❑ Thyroid stimulating hormone (TSH)
   ❑ Other _____
   ❑ No deficiencies of pituitary hormones

9. Does the patient have a genetic or structural hypothalamic-pituitary defect (transcription factor defects [PIT-1, PROP-1, LHX3/4, HESX-1, PITX-2], GHRH receptor-gene defects, GH-gene defects associated with brain structural defects, single central incisor, cleft lip/palate) or an acquired cause (perinatal insults)?
   ❑ Yes ❑ No

10. Did the patient have childhood-onset growth hormone deficiency (GHD)? ❑ Yes ❑ No

11. Does the patient have a congenital abnormality of the central nervous system (CNS), hypothalamus, or pituitary gland? ❑ Yes ❑ No

12. *If patient is requesting for a continuation of therapy,* is the patient's current IGF-1 elevated for age and gender? ***ACTION REQUIRED: If No, collect laboratory report or medical record of current IGF-1 level.***
    ❑ Yes ❑ No ❑ NA, request is NOT for a continuation of therapy

Section D: HIV-Related Wasting

1. Is the patient on anti-retroviral therapy? ❑ Yes ❑ No

2. Indicate the following:
   Pretreatment : Height: _____ cm Weight: _____ lbs / kg Body mass index (BMI): _____ kg/m^2
   Current: Height: _____ cm Weight: _____ lbs / kg Body mass index (BMI): _____ kg/m^2

3. *If new to growth hormone (GH) therapy*, has the patient tried and had a suboptimal response to alternative therapies (e.g., dronabinol, megestrol acetate, cyproheptadine, or testosterone if hypogonadal)?
   If Yes, no further questions. ❑ Yes ❑ No ❑ N/A – patient is currently on growth hormone (GH) therapy

4. Does the patient have a contraindication or intolerance to alternative therapies (i.e., dronabinol, megestrol acetate, cyproheptadine, or testosterone if hypogonadal)? ❑ Yes ❑ No

****Please attach the most recent clinical notes or supporting documentation****

Please complete the following contact information in case additional information is needed.

Office Contact Person:_____ Contact Phone:_____ Ext #: _____

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.

_____

Prescriber (Or Authorized) Signature and Date