

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION REQUEST*

DIRECTIONS: *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process. All questions must be answered.*

Drug Requested: **Growth Hormones (rhGH)** **(MEDICAID)**

DRUG INFORMATION: *Complete all the information below or authorization process will be delayed.*

Drug Name: _____ **Dosage Form:** _____

Strength: _____ **Quantity Per Day:** _____

<i>PREFERRED</i>	<i>NON-PREFERRED</i>	
<input type="checkbox"/> Genotropin® <input type="checkbox"/> Nutropin AQ® NuSpin®	<input type="checkbox"/> Humatrope® cartridge/vial <input type="checkbox"/> Norditropin Nordiflex® <input type="checkbox"/> Omnitrope® <input type="checkbox"/> Tev-Tropin®	<input type="checkbox"/> Norditropin cartridge® <input type="checkbox"/> Nutropin <input type="checkbox"/> Saizen® cartridge/vial <input type="checkbox"/> Zomacton®
		<input type="checkbox"/> Norditropin FlexPro® <input type="checkbox"/> Nutropin AQ® cartridge/vial <input type="checkbox"/> Serostim® <input type="checkbox"/> Zorbtive®

If requesting a non-preferred drug, please document why a preferred drug cannot be used.

Prescriber is: Endocrinologist Nephrologist Infectious Disease
 HIV specialist Other: _____

CLINICAL CRITERIA: *Check ALL boxes below that apply. If not checked, it may affect the outcome of this request. Include chart notes or x-ray evidence with this request.*

1. What is the diagnosis?

<input type="checkbox"/> Pediatric growth hormone (GH) deficiency	<input type="checkbox"/> SHOX deficiency (SHOXD)
<input type="checkbox"/> Idiopathic short stature (ISS)	<input type="checkbox"/> Pediatric chronic kidney disease, <i>skip to diagnosis section</i>
<input type="checkbox"/> Familial short stature	<input type="checkbox"/> Adult GH deficiency
<input type="checkbox"/> Small for gestational age (SGA)	<input type="checkbox"/> HIV-associated wasting, <i>skip to diagnosis section</i>
<input type="checkbox"/> Turner syndrome (TS)	<input type="checkbox"/> Short bowel syndrome (SBS), <i>skip to diagnosis section</i>
<input type="checkbox"/> Noonan syndrome (NS)	<input type="checkbox"/> Treatment of extensive burns, <i>skip to diagnosis section</i>
<input type="checkbox"/> Prader Willi syndrome (PWS)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Chronic renal insufficiency	

2. Is this request for a new start, restart (*re-initiation*) or continuation of Growth Hormone (GH) therapy?

New start, *skip to diagnosis section* Restart, *skip to diagnosis section* Continuation

3. Is the member's growth velocity at least 2 cm per year while on GH therapy? Yes No

Action Required: *If Yes, attach documentation from medical record supporting growth velocity of at least 2cm/year.*

4. Are the growth plates open? **Action Required:** *If Yes AND age is greater than 12 years, attach x-ray evidence from the medical record that shows open growth plates.* Yes No

5. What is the member's current height? **Action Required:** *attach documentation from the medical record of current height.*

Age: Years: _____ Months: _____ Height: inches _____

Complete the following section based on the member's diagnosis. Check ALL that apply.

ALL PEDIATRIC INDICATIONS:

6. What is the member's pretreatment height and age? **Action Required:** *attach documentation from the medical record showing pretreatment height and age at measurement.*

AGE: Years _____ Months _____ **Height:** inches _____

7. Which of the following criteria does the member's pretreatment height meet?
- Greater than or equal to 2.25 standard deviations (SD) below the mean for age and gender
 - Greater than or equal to 2 standard deviations (SD) below the mean for age and gender
 - Greater than or equal to 1 standard deviation (SD) below the mean for age and gender
 - Below the 10th percentile for age
 - None of the above
8. What is the member's pretreatment growth velocity?
- Greater than 1 standard deviation (SD) below the mean for age and gender
 - 1 SD below the mean for age and gender
 - Less than 1 SD below the mean for age and gender
 - Unknown

Action Required: Please attach documentation from the medical record showing either:

- At least 2 heights measured by an endocrinologist at least 6 months apart (data for at least 1 year)
- At least 4 heights measured by a primary care physician at least 6 months apart (data for at least 2 years)

PEDIATRIC GH DEFICIENCY:

9. Did the member have a GH response of less than 10 ng/ml (or otherwise abnormal as determined by the lab) of at least 2 GH stimulation tests? **Action Required:** If Yes, attach documentation of stimulation test results. Yes No
10. Did member have a GH response of less than 15 ng/ml on at least 1 GH stimulation test? Yes No

Action Required: attach documentation of GH stimulation test result. If Yes, please indicate results.

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11. Does the member have a defined CNS pathology, history of cranial irradiation or genetic condition associated GH deficiency? Yes No
12. Does the member have both IGF-1 and IGFBP-3 levels below normal for age and gender? Yes No
- Action Required:** If Yes, attach documentation from the medical record showing IGF 1 and IGFBP 3 levels below normal.
13. Does the member have 2 or more documented pituitary hormone deficiencies other than GH? Yes No
14. Did the member have an abnormally low GH level in association with neonatal hypoglycemia? Yes No

Action Required: If Yes, attach documentation of GH level.

PEDIATRIC CHRONIC KIDNEY DISEASE:

15. Does the member have any of the following? (***Indicate any/all that apply***)
- Creatinine clearance of 75 mL/min/1.73m² or less
 - Serum creatinine greater than 3.0 g/dL
 - Dialysis dependency
 - None of the above
16. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?
- New start, ***no further questions***
 - Restart
 - Continuation
17. Was GH therapy previously approved for this member? Yes No
- What is the member's current height? _____ inches. **If Restart, Action Required:** attach documentation from the medical record of current height.
18. What is the member's current height? **Action Required:** attach documentation from the medical record of current height. Inches _____ **If Restart, no further questions.**
19. Is the member's growth velocity at least 2 cm per year while on GH therapy? Yes No

Action Required: If Yes, attach documentation from medical record supporting growth velocity of at least 2 cm/year.

Section D: Adult GH Deficiency:

20. Does the member have irreversible hypothalamic/pituitary structural lesions or ablation? Yes No
- If Yes, no further questions.***

(continued on next page)

21. Does the member have a defect in GH synthesis? *If Yes, no further questions.* Yes No
22. Did the member have GH deficiency diagnosed during childhood? Yes No
23. Does the member have 3 or more pituitary hormone deficiencies? *If Yes, skip to #31.* Yes No
24. Was the member retested for GH deficiency after an at least 1-month break in GH therapy? Yes No
25. Which of the following pharmacologic agents was used in a GH stimulation test to measure peak GH levels? **Action Required:**
attach documentation showing the results of GH stimulation test.
- Insulin Clonidine Levodopa Glucagon Arginine Other GH stimulation test not performed
26. **Indicate the peak GH level:** _____ **ng/ml**
27. Is the pretreatment IGF-1 level below the laboratory's range of normal? Yes No
Action Required: **attach documentation from the medical record showing the member's pretreatment IGF-1 level.**

Section E: HIV-Associated Wasting:

28. Has the member experienced weight loss greater than 10% of baseline weight that cannot be explained by a concurrent illness other than HIV/AIDS? Yes No
29. Will the member receive antiviral medications for HIV/AIDS concomitantly with GH therapy? Yes No
30. How many months of GH therapy has the member received?

Section F: Short Bowel Syndrome

31. Is the member receiving specialized nutritional support? Yes No
32. Will GH be used in conjunction with optimal management of short-bowel syndrome? Yes No
33. How many months of GH therapy has the member received? **Months:** _____ Not Applicable/New start

Section G: Treatment of Burns

34. Is GH prescribed for a member with extensive 3rd-degree burns? Yes No
35. Do the burns affect at least 40% of total body surface area? Yes No
36. How many months of GH therapy has the member received? **Months:** _____ Not Applicable/New start

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

UPDATED/REVISED: 7/1/2018