# OPTIMA HEALTH COMMUNITY CARE
# AND
# OPTIMA FAMILY CARE
# (MEDICAID)

## 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 HORMONE (RHGH)** | | |
|---|---|---|
| **PREFERRED**<br>❑ **Genotropin®**<br>❑ **Nutropin AQ® NuSpin®** | | |
| **NON-PREFERRED** | | |
| ❑ Humatrope® cartridge/vial | ❑ Norditropin cartridge® | ❑ Norditropin FlexPro® |
| ❑ Norditropin Nordiflex® | ❑ Nutropin | ❑ Nutropin AQ® cartridge/vial |
| ❑ Omnitrope® | ❑ Saizen® cartridge/vial | ❑ Serostim® |
| ❑ Zomacton® | ❑ Zorbtive® | |

**If requesting a non-preferred drug, please document why a PREFERRED drug cannot be used:**

_____

_____

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

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

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

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

_____

_____

_____

**Prescriber is:** ❑ **Endocrinologist** ❑ **Nephrologist**

**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? **(check applicable box below)**

**(continued on next page)**

| | |
|---|---|
| ❑ Idiopathic short stature (ISS) | ❑ Pediatric growth hormone (GH) deficiency |
| ❑ Noonan syndrome (NS) | ❑ Familial short stature |
| ❑ SHOX deficiency (SHOXD) | ❑ Small for gestational age (SGA) |
| ❑ Adult GH deficiency | ❑ Turner syndrome (TS) |
| ❑ Prader Willi syndrome (PWS) | ❑ Short bowel syndrome (SBS), **skip to diagnosis section** |
| ❑ Chronic renal insufficiency | ❑ Pediatric chronic kidney disease, **skip to diagnosis section** |
| ❑ Other: _____ | |

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? ❑ Yes ❑ No

5. What is the member's current height?

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

   **Action Required*: attach documentation from the medical record of current height.***

**DIAGNOSIS AND MEDICAL INFORMATION: Complete the following section based on the member's diagnosis. Check ALL that apply.**

## Section A: All Pediatric Indications

6. What is the member's pretreatment height and age?

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

   **Action Required**: attach documentation from the medical record showing pretreatment height and age at measurement.

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

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

**(continued on next page)**

**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)

## Section B: 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? ❑ Yes ❑ No

   **Action Required: If Yes, attach documentation of stimulation test results.**

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.**

    _____

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.**

## Section C: Pediatric Chronic Kidney Disease/Chronic Renal Insufficiencies

15. Does the member have any of the following? **(Indicate any/all that apply)**

- ❑ Creatinine clearance of 75 mL/min/1.73m2 or less
- ❑ Dialysis dependency
- ❑ Serum creatinine greater than 3.0 g/dL
- ❑ None of the above

## Section D: Pediatric Chronic Kidney Disease

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

18. What is the member's current height in inches? _____

    **Action Required: attach documentation from the medical record of current height. 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.**

**(continued on next page)**

## Section E: Adult GH Deficiency:

20. Does the member have irreversible hypothalamic/pituitary structural lesions or ablation? ❑ Yes ❑ No

**If Yes, no further questions.**

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?

| | | |
|---|---|---|
| ❑ Insulin | ❑ Clonidine | ❑ Levodopa Glucagon |
| ❑ Arginine | ❑ GH stimulation test not performed | ❑ Other: _____ |

**Action Required: attach documentation showing the results of GH stimulation test.**

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 F: Short Bowel Syndrome

30. Is the member receiving specialized nutritional support? ❑ Yes ❑ No

31. Will GH be used in conjunction with optimal management of short-bowel syndrome? ❑ Yes ❑ No

32. 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:** ~~6/30/2017; 8/29/2017; 8/19/2018;~~ **1/2/2019**;