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	**NON-PREFERRED**
❑ **Genotropin®** ❑ **Nutropin AQ® NuSpin®**	❑ Humatrope® cartridge/vial ❑ Norditropin FlexPro® ❑ Nutropin ❑ Nutropin AQ® cartridge/vial ❑ Saizen® cartridge/vial ❑ Tev- Tropin® ❑ Norditropin cartridge® ❑ Norditropin Nordiflex® ❑ Omnitrope® ❑ Serostim® ❑ Zomacton® ❑ Zorbtive®

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 ❑ 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?

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

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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

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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
- ❑ Dialysis dependency
- ❑ Serum creatinine greater than 3.0 g/dL
- ❑ 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.

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

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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: ~~6/30/2017;~~ ~~8/29/2017;~~ **8/19/2018**