

# OPTIMA HEALTH PLAN

## 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 form will delay authorization process.

### COMMERCIAL ONLY

**DRUG INFORMATION:** Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

**\*\*\*IDIOPATHIC SHORT STATURE AND INTRAUTERINE GROWTH & SGA RETARDATION ARE NOT COVERED INDICATIONS\*\*\***

**DRUG REQUESTED:** Recombinant Growth Hormone (rhGH).

Formulary HGH:	Non-Formulary HGH		
<input type="checkbox"/> Omnitrope®	<input type="checkbox"/> Genotropin®	<input type="checkbox"/> Humatrope®	<input type="checkbox"/> Zomacton™
	<input type="checkbox"/> Norditropin®	<input type="checkbox"/> Nutropin®	<input type="checkbox"/> Nutropin AQ®
	<input type="checkbox"/> Serostim®	<input type="checkbox"/> Saizen®	<input type="checkbox"/> Zorbitive®

**CLINICAL CRITERIA:** Check ALL boxes below that apply. Boxes must be checked or authorization process will be delayed and may affect the outcome of this request.

*Non-Preferred HGH agents require a trial of Omnitrope® within the previous 6 months for new starts unless non-formulary agent has FDA approved indication that is not approved for the formulary agent. Please check boxes:*

- Patient had adverse reaction to formulary (define)  Yes  No
- Patient has tried a preferred HGH within the previous 6 months  Yes  No

**Diagram A: (Must be filled out for Adult and Children)**

<b>Growth Hormone Stimulation Test:</b>	<input type="checkbox"/> Insulin Induced Hypoglycemia <input type="checkbox"/> Arginine-GHRH <input type="checkbox"/> Arginine <input type="checkbox"/> Glucagons <input type="checkbox"/> Clonidine <input type="checkbox"/> L-dopa <input type="checkbox"/> Propranolol <input type="checkbox"/> Other		
Check all the stimulation test Date: ____/____/____			

**Appropriate Evaluation of Stimulation Test Results and Reagents Used: Attach Copy of Results**

<b>GH Results, IGF-1/ IGFBP-3</b> (Peak GH concentration): _____	Date: _____ Concentration: _____	Date: _____ Concentration: _____	<b>No Stimulation Testing</b> (Reason) _____ _____
--	-------------------------------------	-------------------------------------	--

**DIAGNOSES:** Choose only ONE (1) of the diagnoses that applies to patient.  
Growth Hormone Use in Children:

Male       Female      Patients Height: \_\_\_\_\_      Growth velocity: \_\_\_\_\_  
Patients Chronological Age: \_\_\_\_\_

<input type="checkbox"/> GHD	<input type="checkbox"/> Cranial irradiation	<input type="checkbox"/> Turner Syndrome	<input type="checkbox"/> Noonan Syndrome
<input type="checkbox"/> 3 <sup>rd</sup> Burn	<input type="checkbox"/> Growth Delay chronic renal failure	<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> SHOX (short stature homeobox-gene)

(continued on next page)

**Auxologic evaluation:** Include **ONE** of the following:

- Height is >2 SD below average for population mean height for age and sex, **AND** height velocity measured over 1 year is >1 SD below the mean for chronological age

**OR**

- Children >2years old, there is a decrease in height SD of >0.5 over one year
- Height velocity measured over 1 year is more than 2 SD below the mean for age and sex

**OR**

- >1.5 SD below the mean sustained over 2 years

**\*\*\*Yearly reassessment for reauthorization of coverage is required\*\*\***

**Continuation of Therapy:** Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth curve chart. Coverage for growth promotion will cease when the bony epiphyses have closed.

**For continued therapy every year:**

- Has the growth rate remained above 2.5cm per year?  Yes  No

**For children over 10 years of age:**

- X-ray report that shows that the epiphysis has not yet closed?  Yes  No

**Growth Hormone Use in Adults: (check all that apply) Diagram A must be filled out**

<input type="checkbox"/> Destructive Hypothalamic or Pituitary Disease	<input type="checkbox"/> Surgery or Trauma
<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Documented GHD in childhood

**\*\*\*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 #: \_\_\_\_\_

\*Approved by Pharmacy and Therapeutics Committee: 4/17/2014

UPDATED/REVISED: 4/22/2014; 5/16/2014; 10/31/2014; 5/21/2015; 12/27/2015; 12/16/2016; 2/23/2017; 9/21/2017;