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).**

PREFERRED HGH:	**Non-Preferred HGH**		
❑ **Omnitrope®** ❑ **Norditropin®** ❑ **Nutropin®/❑ Nutropin AQ®**	❑ Genotropin®	❑ Humatrope®	❑ Zomacton™
	❑ Serostim®	❑ Saizen®	❑ Zorbtive®

***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. ALL chart notes MUST be attached to this request form.**

Non-Preferred HGH agents require a trial of ALL three (3) PREFERED human growth hormone products 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 product ***(chart notes MUST be submitted for documentation):***
  ❑ Yes ❑ No
- Patient has tried and failed ***ALL three (3) preferred*** HGH products within the previous ***6 months*** ***(chart notes MUST be submitted for documentation):***
  ❑ Yes ❑ No

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

Growth Hormone Stimulation Test: Check all the stimulation test **Date:** _____/_____/_____	❑ Insulin Induced Hypoglycemia ❑ Arginine-GHRH ❑ Arginine ❑ Glucagons ❑ Clonidine ❑ L-dopa ❑ Propranolol ❑ Other

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

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

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

❑ Male ❑ Female Patients Height: _____ 12-month growth velocity:_____

Patients Chronological Age: _____

❑ GHD	❑ Cranial irradiation	❑ Turner Syndrome	❑ Noonan Syndrome
❑ 3rd Burn	❑ Growth Delay chronic renal failure	❑ Prader-Willi Syndrome	❑ 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

- ❑ Height velocity of >1.5 SD below the mean has been sustained over 2 years

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. Yearly reassessment for reauthorization of coverage is required

***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 been completed ***(current X-ray report MUST be submitted)***? ❑ Yes ❑ No

Growth Hormone Use in Adults: (check all that apply) Diagram A must be filled out		
❑ Destructive Hypothalamic or Pituitary Disease	❑ Surgery or Trauma	❑ Radiation Therapy

*****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; **1/18/2018**;
UPDATED/REVISED: 4/22/2014; 5/16/2014; **10/31/2014**; 5/21/2015; 12/27/2015; 12/16/2016; 2/23/2017; 8/13/2017; 11/24/2017; **2/21/2018**;