Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Growth Hormones Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

For adults:

- ❑ Destructive hypothalamic or pituitary disease
- ❑ Documented growth hormone deficiency (GHD) in childhood
- ❑ Radiation therapy
- ❑ Surgery or trauma

For children:

- ❑ 3rd degree burn
- ❑ Cranial irradiation
- ❑ Growth delay chronic renal failure
- ❑ Growth hormone deficiency (GHD)
- ❑ Prader-Willi Syndrome
- ❑ Noonan Syndrome
- ❑ SHOX (short stature homeobox-gene)
- ❑ Turner Syndrome

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Has the patient tried Omnitrope within the previous 6 months? ❑ **Yes** ❑ **No**

Has the patient had an adverse reaction to Omnitrope? ❑ **Yes** ❑ **No**

If "yes" to the above question, please document the reaction: _____

Select if the patient has had the following growth hormone stimulation tests:

- ❑ Arginine
- ❑ Arginine-GHRH
- ❑ Clonidine
- ❑ Glucagon
- ❑ Insulin Induced Hypoglycemia
- ❑ L-dopa
- ❑ Propranolol

Please submit documentation of the growth hormone stimulation test completed including test date, results, and reagents used

Growth Hormones Prior Authorization Request Form (Page 2 of 2)

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For 3rd degree burn, cranial irradiation, growth delay chronic renal failure, growth hormone deficiency (GHD), Prader-Willi Syndrome, Noonan Syndrome, SHOX (short stature homeobox-gene), Turner Syndrome, also answer the following:

Document the patient's height: _____

Document the patient's chronological age: _____

Document the patient's growth velocity: _____

Select if the patient has had an auxologic evaluation that includes the following:

- ❑ Height is greater than 2 standard deviations (SD) below average for population mean height for age and sex
- ❑ Height velocity measured over 1 year is greater than 1 SD below the mean for chronological age
- ❑ There is a decrease in height SD of greater than 0.5 over one year
- ❑ Height velocity measured over 1 year is more than 2 SD below the mean for age and sex
- ❑ Height velocity is greater than 1.5 SD below the mean sustained over 2 years

Reauthorization:

If this is a reauthorization request, answer the following questions:

Does patient's growth rate remain above 2.5cm per year? ❑ **Yes** ❑ **No**

For children over 10 years of age, does X-ray report show that the epiphysis has not yet closed? ❑ **Yes** ❑ **No**

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.