

**Growth Hormone Prior Authorization Form**

**Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Drug Information**

**Drug Name:** \_\_\_\_\_ **Strength:** \_\_\_\_\_ **NDC:** \_\_\_\_\_

**Daily Dose:** \_\_\_\_\_ **Fill Date:** \_\_\_\_\_ **Fill Quantity:** \_\_\_\_\_ **Day Supply:** \_\_\_\_\_

**Pharmacy Information**

**Pharmacy NPI:** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_

**Pharmacy Phone:** \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_

**Prescriber Information**

**Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_

**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**Criteria**

**All information must be provided and SoonerCare may verify through further requested documentation. The member's drug history will be reviewed prior to approval. Please complete and return all pages. Failure to complete all pages will result in processing delays.**

**For Initial Authorization (Initial approval will be for the duration of 6 months):**

**1. Please indicate the member's diagnosis:**

- Growth hormone deficiency (GHD) of 1 of the following types:
  - Classic GHD as determined by childhood GH stimulation tests; or
  - Panhypopituitarism; or
  - Hypoglycemia with evidence for GHD; or
  - Neurosecretory dysfunction; or
  - Other evidence for GHD submitted for panel review and decision; or
- Short stature associated with Prader-Willi syndrome; or
- Short stature associated with Noonan syndrome; or
- Short stature associated with chronic renal insufficiency (pre-transplantation and CrCl <50mL/min); or
- Growth failure in children born small for gestational age (SGA); or
- Idiopathic short stature (ISS); or
- Turner syndrome or 45X, 46XY mosaicism; or
- Short-stature homeobox-containing gene (SHOX) deficiency with genetic evidence for SHOX deficiency

**2. For initial requests, please complete the following information:**

- A. Date of most recent clinic visit: \_\_\_\_\_
- B. Member's weight (kg): \_\_\_\_\_ Member's height (cm): \_\_\_\_\_
- C. Mother's height (cm) \_\_\_\_\_ Father's height (cm): \_\_\_\_\_
- D. Does the member have open epiphyses? Yes \_\_\_ No \_\_\_ Date assessed: \_\_\_\_\_
- E. Growth velocity (cm/yr): \_\_\_\_\_
- F. Bone Age: \_\_\_ Yr \_\_\_ Mo; Chronological Age: \_\_\_ Yr \_\_\_ Mo; Date of Scan: \_\_\_\_\_
- G. Have all causes for short stature, other than GH deficiency, been ruled out? Yes \_\_\_ No \_\_\_
- H. Does the member have hypoglycemia? Yes \_\_\_ No \_\_\_ Glucose: \_\_\_\_\_ mg/dL
  - i. If yes, provide additional evidence of GHD: \_\_\_\_\_
- I. Please provide provocative growth hormone stimulation test results:
  - Agent: (a) \_\_\_\_\_ (b) \_\_\_\_\_ Peak: (a) \_\_\_\_\_ (b) \_\_\_\_\_ Date \_\_\_\_\_
- J. IGF-1 level & reference range: \_\_\_\_\_

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PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:

University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization Unit

Fax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4

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**Criteria**

**2. For initial requests, continued:**

- K. Is the member receiving hormone replacement therapy? Yes \_\_\_ No \_\_\_  
If yes, please list: \_\_\_\_\_
- L. Was the member or member's caregiver(s) counseled on proper administration and storage of the requested medication? Yes \_\_\_ No \_\_\_
- M. Is medication prescribed by an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist)? Yes \_\_\_ No \_\_\_
- N. For **panhypopituitarism diagnosis**:
  - i. Does the member have a history of pituitary or hypothalamic injury due to tumor, trauma, surgery, documented whole brain radiation, irradiation, hemorrhage or infarction, or a congenital anomaly? Yes \_\_\_ No \_\_\_
    - a. If yes, does the member lack the hormones testosterone, luteinizing hormone, or follicle-stimulating hormone? Yes \_\_\_ No \_\_\_
    - b. If no, does the member have an MRI showing evidence of pituitary stalk agenesis, empty sella, or ectopic posterior pituitary "bright spot"? Yes \_\_\_ No \_\_\_
  - ii. Is the member deficient in  $\geq 3$  pituitary hormones? Yes \_\_\_ No \_\_\_
  - iii. Is there evidence of tumor recurrence or growth? Yes \_\_\_ No \_\_\_
- O. Is member at risk for growth hormone deficiency due to CNS radiation or other organic causes? Yes \_\_\_ No \_\_\_
- P. For **chronic renal insufficiency diagnosis**:
  - i. CrCl: \_\_\_\_\_ mL/min; Is member pre-transplant? Yes \_\_\_ No \_\_\_
- Q. For **small for gestational age (SGA) diagnosis**:
  - i. Birth weight (kg): \_\_\_\_\_; Gestational age (weeks): \_\_\_\_\_
  - ii. Is birth weight or length below the 3rd percentile for gestational age? Yes \_\_\_ No \_\_\_
- R. For **Prader-Willi syndrome (PWS), Turner syndrome, 45X, 46XY, Noonan syndrome, or SHOX deficiency**, was the diagnosis confirmed by a chromosome analysis? Yes \_\_\_ No \_\_\_
- S. For **SHOX deficiency diagnosis**:
  - i. Does member have a normal endocrine screen? Yes \_\_\_ No \_\_\_
  - ii. Does member have evidence of growth hormone deficiency or insensitivity, tumor activity, diabetes mellitus, history of glucose tolerance, or other serious illness known to interfere with growth? Yes \_\_\_ No \_\_\_
- T. Is member transitioning to adult dosing? Yes \_\_\_ No \_\_\_

**3. For continued approval, please complete the following information:**

- A. Date of most recent clinic visit: \_\_\_\_\_
- B. Member's weight (kg): \_\_\_\_\_ Member's height (cm): \_\_\_\_\_
- C. Open epiphyses? Yes \_\_\_ No \_\_\_ Date assessed: \_\_\_\_\_
- D. Growth velocity (cm/yr): \_\_\_\_\_
- E. For members on adult growth hormone dosing, please provide:
  - i. IGF-1 level: \_\_\_\_\_; Reference range: \_\_\_\_\_
  - ii. IGF-1 standard deviation score (SDS): \_\_\_\_\_; Date measured: \_\_\_\_\_

Additional Information: \_\_\_\_\_

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**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Failure to complete this form in full will result in processing delays.***

<p align="center"><u>PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:</u></p> <p align="center">University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit</p> <p align="center">Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4</p>	<p align="center"><u>CONFIDENTIALITY NOTICE</u></p> <p align="center"><i>This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.</i></p>
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