



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

SW Exchange Non-Formulary Growth Hormone

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

| | | |
|---------------------------|--|---------------|
| Patient Name: | Prescriber Name: | |
| | Supervising Physician: | |
| Member/Subscriber Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Group Number: | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

| |
|---|
| Q1. Is this being prescribed by an endocrinologist or a pediatric endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Q2. What is the patient's age? <input type="checkbox"/> Greater than 18 years (go to question 3) <input type="checkbox"/> Less than or equal to 18 years (go to question 10) |
| Q3. Adults: For what diagnosis is this drug being prescribed (pick one)? <input type="checkbox"/> Growth hormone deficiency (GHD) <input type="checkbox"/> Other |
| Q4. Does the patient have irreversible hypothalamic-pituitary disease (etiologies may include radiation therapy, surgery, or trauma)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Q5. Does the patient have low IGF-1 level (e.g. less than 2.5 percentile or less than -2 standard deviations)? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Q6. Does the patient have a negative response to GH stimulation testing (peak GH < 5 µg/L) based on insulin tolerance test? (Acceptable alternative stimulation tests: growth hormone releasing hormone (GHRH) + arginine (ARG), glucagon |



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| Patient Name: | Prescriber Name: Supervising Physician: |
| or ARG) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q7. Has the patient previously been treated for Childhood-Onset Growth Hormone Deficiency (COGHD) with GH therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q8. Does the patient have pan-hypopituitarism (greater than or equal to 3 pituitary hormone deficiencies)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q9. Does the patient have low IGF-1 level (e.g. less than 2.5 percentile or less than -2 standard deviations)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q10. Pediatrics: For what diagnosis is this drug being prescribed (pick one)? <input type="checkbox"/> Growth hormone deficiency (GHD) <input type="checkbox"/> Turner syndrome (TS) <input type="checkbox"/> Small for gestational age (SGA) <input type="checkbox"/> Growth failure in children with chronic renal insufficiency <input type="checkbox"/> Prader-Willi syndrome (PWS) <input type="checkbox"/> Noonan syndrome (and other FDA-approved dwarfing syndromes) <input type="checkbox"/> Other | |
| Q11. Please provide ICD code(s) for diagnosis. | |
| Q12. Pediatrics: Is this request for a patient being newly started on GH therapy for GHD? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q13. Pediatric GHD new start: Does the patient have marked short stature defined as height less than 3rd percentile (e.g. > 2 standard deviations (SD) below the mean for age and gender)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q14. Pediatric GHD new start: Does the patient have growth failure defined as height velocity less than 3rd percentile (e.g. < 2 SD below mean for age)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q15. Pediatric GHD new start: Does the patient have less severe short stature combined with moderate growth failure (e.g. growth velocity < 15th percentile or less than 1 SD)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |



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| Patient Name: | Prescriber Name: Supervising Physician: |
| Q16. Pediatric GHD new start: Does the patient have a documented GHD as evidenced by low IGF-1 and/or IGFBP-3 levels (e.g. values > 2 SD below the mean for IGF-1 or IGFB-3)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q17. Pediatric GHD new start: Does the patient have diminished serum growth hormone level based on TWO of the following stimulation tests: arginine, glucagon, or clonidine? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q18. Pediatric GHD continuation: Does the patient have a documented epiphyseal closure? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q19. Pediatric GHD continuation: Does the patient have a growth rate velocity of greater than or equal to 2.5 cm/year? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q20. Pediatrics: Is this request for a patient being newly started on GH therapy for TS? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q21. Pediatric TS new start: Has the patient been diagnosed with TS using chromosome analysis? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q22. Pediatric TS new start: Does the patient have short stature? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q23. Pediatric TS continuation: Does the patient have a bone age of greater than or equal to 14 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q24. Pediatrics: Is this request for a patient being newly started on GH therapy for SGA? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q25. Pediatric SGA new start: Has the patient's height remained less than 3rd percentile (e.g. > 2 SDS below the mean for age and sex) at 2 years of age? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q26. Pediatric SGA continuation: Does the patient have a growth rate velocity of greater than or equal to 2.5 cm/year? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q27. Pediatrics: Is this request for a patient being newly started on GH therapy for growth failure due to chronic renal insufficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Q28. Pediatric chronic renal insufficiency new start: Has growth failure persisted after other factors contributing to uremic | |



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growth failure have been adequately stabilized and prior to kidney transplantation?

☐ Yes

☐ No

Q29. Pediatric chronic renal insufficiency continuation: Does the patient have a documented epiphyseal closure?

☐ Yes

☐ No

Q30. Pediatric chronic renal insufficiency continuation: Has the patient had a renal transplant?

☐ Yes

☐ No

Q31. Pediatrics: Is this request for a patient being newly started on GH therapy for PWS?

☐ Yes

☐ No

Q32. Pediatric PWS new start: Has the patient been diagnosed with PWS using chromosome analysis and/or appropriate genetic evaluation?

☐ Yes

☐ No

Q33. Pediatric PWS new start: Does the patient have growth failure?

☐ Yes

☐ No

Q34. Pediatric PWS new start: Is the patient's weight greater than 225% of ideal body weight (e.g. severely obese)?

☐ Yes

☐ No

Q35. Pediatric PWS new start: Does the patient have respiratory impairment or sleep apnea (evaluated by polysomnography)?

☐ Yes

☐ No

Q36. Pediatric PWS continuation: Does the patient have a documented epiphyseal closure?

☐ Yes

☐ No

Q37. Pediatric PWS continuation: Has the patient had new onset respiratory impairment or sleep apnea?

☐ Yes

☐ No

Q38. Pediatrics: Is this request for a patient being newly started on GH therapy for Noonan syndrome (or other FDA-approved dwarfing syndromes)?

☐ Yes

☐ No

Q39. Pediatric dwarfing syndrome new start: Does the patient have short stature?

☐ Yes

☐ No

Q40. Pediatric dwarfing syndrome continuation: Does the patient have a documented epiphyseal closure?



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☐ Yes

☐ No

Q41. Norditropin is the formulary growth hormone. Please indicate why the patient cannot take Norditropin for this condition or provide rationale for not using.

Q42. Additional Comments

Prescriber Signature

Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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