PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormones

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. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (drug from pharmacy with a prescription)

Q2. Is this being prescribed by an endocrinologist or a pediatric endocrinologist?

☐ Yes ☐ No

Q3. What is the patient's age?

- ☐ Greater than 18 years (go to question 4)
- ☐ Less than or equal to 18 years (go to question 11)

Q4. Adults: For what diagnosis is this drug being prescribed (pick one)?

- ☐ Growth hormone deficiency (GHD)
- ☐ Other

Q5. Does the patient have irreversible hypothalamic-pituitary disease (etiologies may include radiation therapy, surgery, or trauma)?

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormones

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:**

☐ Yes ☐ No

Q6. Does the patient have low IGF-1 level (e.g. less than 2.5 percentile or less than -2 standard deviations)?

☐ Yes ☐ No

Q7. 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 or ARG)

☐ Yes ☐ No

Q8. Has the patient previously been treated for Childhood-Onset Growth Hormone Deficiency (COGHD) with GH therapy?

☐ Yes ☐ No

Q9. Does the patient have pan-hypopituitarism (greater than or equal to 3 pituitary hormone deficiencies)?

☐ Yes ☐ No

Q10. Does the patient have low IGF-1 level (e.g. less than 2.5 percentile or less than -2 standard deviations)?

☐ Yes ☐ No

Q11. Pediatrics: For what diagnosis is this drug being prescribed (pick one)?

- ☐ Growth hormone deficiency (GHD)
- ☐ Turner syndrome (TS)
- ☐ Small for gestational age (SGA)
- ☐ Growth failure in children with chronic renal insufficiency
- ☐ Prader-Willi syndrome (PWS)
- ☐ Noonan syndrome (and other FDA-approved dwarfing syndromes)
- ☐ Other

Q12. Please provide ICD code(s) for diagnosis.

Q13. Pediatrics: Is this request for a patient being newly started on GH therapy for GHD?

☐ Yes ☐ No

Q14. 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)?

☐ Yes ☐ No

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormones

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:**

Q15. 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)?

☐ Yes ☐ No

Q16. 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)?

☐ Yes ☐ No

Q17. 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 IFG-1 or IFGB-3)?

☐ Yes ☐ No

Q18. 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?

☐ Yes ☐ No

Q19. Pediatric GHD continuation: Does the patient have a documented epiphyseal closure?

☐ Yes ☐ No

Q20. Pediatric GHD continuation: Does the patient have a growth rate velocity of greater than or equal to 2.5 cm/year?

☐ Yes ☐ No

Q21. Pediatrics: Is this request for a patient being newly started on GH therapy for TS?

☐ Yes ☐ No

Q22. Pediatric TS new start: Has the patient been diagnosed with TS using chromosome analysis?

☐ Yes ☐ No

Q23. Pediatric TS new start:Does the patient have short stature?

☐ Yes ☐ No

Q24. Pediatric TS continuation: Does the patient have a bone age of greater than or equal to 14 years of age?

☐ Yes ☐ No

Q25. Pediatrics: Is this request for a patient being newly started on GH therapy for SGA?

☐ Yes ☐ No

Q26. Pediatric SGA new start: Has the patient's height remained less than 3rd percentile (e.g. > 2 SDS below the

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormones

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:**

mean for age and sex) at 2 years of age?

☐ Yes ☐ No

Q27. Pediatric SGA continuation: Does the patient have a growth rate velocity of greater than or equal to 2.5 cm/year?

☐ Yes ☐ No

Q28. Pediatrics: Is this request for a patient being newly started on GH therapy for growth failure due to chronic renal insufficiency?

☐ Yes ☐ No

Q29. Pediatric chronic renal insufficiency new start: Has growth failure persisted after other factors contributing to uremic growth failure have been adequately stabilized and prior to kidney transplantation?

☐ Yes ☐ No

Q30. Pediatric chronic renal insufficiency continuation: Does the patient have a documented epiphyseal closure?

☐ Yes ☐ No

Q31. Pediatric chronic renal insufficiency continuation: Has the patient had a renal transplant?

☐ Yes ☐ No

Q32. Pediatrics: Is this request for a patient being newly started on GH therapy for PWS?

☐ Yes ☐ No

Q33. Pediatric PWS new start: Has the patient been diagnosed with PWS using chromosome analysis and/or appropriate genetic evaluation?

☐ Yes ☐ No

Q34. Pediatric PWS new start: Does the patient have growth failure?

☐ Yes ☐ No

Q35. Pediatric PWS new start: Is the patient's weight greater than 225% of ideal body weight (e.g. severely obese)?

☐ Yes ☐ No

Q36. Pediatric PWS new start: Does the patient have respiratory impairment or sleep apnea (evaluated by polysomnography)?

☐ Yes ☐ No

Q37. Pediatric PWS continuation: Does the patient have a documented epiphyseal closure?

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormones

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:**

☐ Yes ☐ No
Q38. Pediatric PWS continuation: Has the patient had new onset respiratory impairment or sleep apnea? ☐ Yes ☐ No
Q39. Pediatrics: Is this request for a patient being newly started on GH therapy for Noonan syndrome (or other FDA-approved dwarfing syndromes)? ☐ Yes ☐ No
Q40. Pediatric dwarfing syndrome new start: Does the patient have short stature? ☐ Yes ☐ No
Q41. Pediatric dwarfing syndrome continuation: Does the patient have a documented epiphyseal closure? ☐ Yes ☐ No
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.

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Growth Hormones

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.**

	Prescriber Name:
Patient Name:	**Supervising Physician:**