



Please complete ALL information below and fax your request to 1-888-671-5285

Growth Hormones Prior Authorization Request Form (Page 1 of 3)

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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:
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> AIDS wasting syndrome					
<input type="checkbox"/> Growth failure associated with chronic kidney disease (CKD)					
<input type="checkbox"/> Growth hormone deficiency in adults with adult-onset hypothalamic pituitary disease					
<input type="checkbox"/> Growth hormone deficiency in adults with childhood-onset hypothalamic or pituitary disease					
<input type="checkbox"/> Growth hormone deficiency in children					
<input type="checkbox"/> Hypopituitarism in childhood					
<input type="checkbox"/> Idiopathic short stature in children					
<input type="checkbox"/> Noonan syndrome					
<input type="checkbox"/> Prader-Willi syndrome					
<input type="checkbox"/> Short stature homeobox containing gene (SHOX) deficiency					
<input type="checkbox"/> Small for gestational age					
<input type="checkbox"/> Turner syndrome					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information					
Select if the requested medication is prescribed by one of the following specialists:					
<input type="checkbox"/> Endocrinologist <input type="checkbox"/> Nephrologist (for patients with chronic kidney disease)					
Select if the patient has had an inadequate response or inability to tolerate the following:					
<input type="checkbox"/> Norditropin					
<input type="checkbox"/> Nutropin/Nutropin AQ					
<input type="checkbox"/> Omnitrope					
For AIDS wasting syndrome, also answer the following:					
Does the patient have a diagnosis of wasting (cachexia) associated with HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient on concomitant antiretroviral therapy that has been optimized to decrease viral load? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the patient's current weight less than 90 percent of ideal body weight? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient had a nutritional evaluation since onset of wasting first occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization:					
Is there documentation the patient has had a positive response to therapy (i.e., greater than or equal to 2% increase in body weight and/or body cell mass)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

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Office use only: GrowthHormones_FSVF_2019Apr1-W

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For growth failure associated with chronic kidney disease (CKD), also answer the following:Does the patient have height that is below the third percentile on standardized growth charts? Yes NoIs the patient a renal transplant recipient? Yes No**Reauthorization:**Is the patient a renal transplant recipient? Yes NoDoes the patient have a growth velocity greater than or equal to 2.5 cm/year? Yes NoHas the patient received a yearly evaluation by an endocrinologist or nephrologist? Yes No**For growth hormone deficiency in adults with adult-onset hypothalamic pituitary disease, also answer the following:**Does the patient have clinical history of hypothalamic or pituitary disease of organic origin? Yes No

Select if the patient has deficiency in the following:

- Adrenocorticotropic hormone (ACTH) (demonstrated by a low early morning serum cortisol and an ACTH that is not elevated)
- Follicle-stimulating hormone (FSH) and luteinizing hormone (LH) (demonstrated by a low early morning serum testosterone concentration or a low serum estradiol concentration while FSH and LH concentrations are not elevated)
- Thyroid stimulating hormone (TSH) (demonstrated by a low serum T4 concentration and TSH concentration that is not elevated)

Does the patient have serum IGF-1 concentration that is subnormal for age and gender? Yes NoDoes the patient have a GH response of less than 5 ng/mL to insulin-induced hypoglycemia? Yes No**Reauthorization:**Does the patient have normalization of serum IGF-1 concentration for age and gender? Yes NoHas the patient received a yearly evaluation by an endocrinologist? Yes No**For growth hormone deficiency in adults with childhood onset hypothalamic or pituitary disease, also answer the following:**Does the patient have clinical history of organic or idiopathic panhypopituitarism as a child? Yes NoDoes the patient have history of idiopathic, isolated GH deficiency in childhood as documented by a serum IGF-1 concentration that is subnormal for age and gender OR a GH response of less than 5ng/mL to insulin-induced hypoglycemia? Yes No**Reauthorization:**Does the patient have normalization of serum IGF-1 concentration for age and gender? Yes NoHas the patient received a yearly evaluation by an endocrinologist? Yes No**For growth hormone deficiency in children, also answer the following:**Does the patient have subnormal serum insulin-like growth factor-1 (IGF-1)? Yes NoDoes the patient have a growth velocity less than or equal to 5 cm/year after 2 years of age? Yes No

Please document the bone age determination: _____

Select if the patient has the following responses from provocative testing:

- Abnormal response on insulin-induced hypoglycemia test (less than 5 ng/ml)
- Abnormal response of less than 10 ng/ml to any other two provocative tests (performed sequentially, not simultaneously), such as but not limited to levodopa and clonidine

Reauthorization:Does the patient have a growth velocity greater than or equal to 2.5 cm/year? Yes NoHas the patient received a yearly evaluation by an endocrinologist? Yes No**For hypopituitarism in childhood, also answer the following:**Does the patient have clinical evidence of a pituitary lesion or midline central nervous system defect? Yes NoDoes the patient have growth velocity less than or equal to 5 cm/year after 2 years of age? Yes NoIs there documentation the patient has a subnormal serum IGF-1 level? Yes NoIs there documentation the patient has had provocative testing, such as but not limited to: levodopa, clonidine, insulin-induced hypoglycemia? Yes NoDoes the patient have deficiencies in two or more other hypothalamic-pituitary axes? Yes No**Reauthorization:**Does the patient have normalization of serum IGF-1 concentration for age and gender? Yes NoHas the patient received a yearly evaluation by an endocrinologist? Yes No



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For idiopathic short stature in children, also answer the following:

Does the patient have a height less than or equal to 2.25 standard deviations from the mean (1.2 percentile)? Yes No

Please document the growth velocity: _____

Does the patient have open epiphyses? Yes No

Reauthorization:

Has the patient's growth velocity increased by at least 50% from baseline? Yes No

Has the patient received a yearly evaluation by an endocrinologist? Yes No

For Noonan syndrome, also answer the following:

Reauthorization:

Has the patient received a yearly evaluation by an endocrinologist? Yes No

For Prader-Willi syndrome, also answer the following:

Reauthorization:

Has the patient received a yearly evaluation by an endocrinologist? Yes No

For short stature homeobox containing gene (SHOX) deficiency, also answer the following:

Does the patient have a diagnosis of short stature or growth failure? Yes No

Does the patient have open epiphyses? Yes No

Reauthorization:

Has the patient received a yearly evaluation by an endocrinologist? Yes No

For small for gestational age, also answer the following:

Did the patient fail to reach the third percentile for length/height by 2 years of age (for Omnitrope requests) or 2 to 4 years of age (for Norditropin requests)? Yes No

Select if the following applies to the patient:

- A birth length and/or weight less than the third percentile for gestational age
- A birth weight less than 2500 grams and gestational age greater than 37 weeks

Reauthorization:

Does the patient have a growth velocity greater than or equal to 2.5 cm/year? Yes No

Has the patient received a yearly evaluation by an endocrinologist? Yes No

For Turner syndrome, also answer the following:

Reauthorization:

Does the patient have a growth velocity greater than or equal to 2.5 cm/year? Yes No

Has the patient received a yearly evaluation by an endocrinologist? Yes No

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.