

ADULT (≥18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM



**OptumRx**  
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Today's Date

□□ / □□ / □□□□

**Note: This form must be completed by the prescribing provider.**

**\*\*All sections must be completed or the request will be returned\*\***

Patient's Medicaid #	□□□□□□□□□□	Date of Birth	□□ / □□ / □□□□
Patient's Name		Prescriber's Name	
Prescriber's IN License #	□□□□□□□□	Specialty	
Prescriber's NPI #	□□□□□□□□□□	Prescriber's Signature	
Return Fax #	□□□□ - □□□□ - □□□□	Return Phone #	□□□□ - □□□□ - □□□□
Check box if requesting retro-active PA <input type="checkbox"/>		Date(s) of service requested for retro-active eligibility (if applicable):	

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

Requested Medication and Strength	Dosage	Treatment Duration

**SOMATROPIN AGENTS – Initial Authorization**

**Please select one of the following:**

Member is transitioning from pediatric growth hormone therapy

**\*Must meet all of the following\***

- Member has reached adult height
- Member stopped growth hormone therapy for at least 1 month before re-evaluation of the need for continued therapy
- Prescriber has determined that member will experience growth hormone deficiency into adulthood and would receive clinical benefit from continued growth hormone therapy

Please select one of the following:

Request is for a preferred agent

Request is for a non-preferred agent with a product-specific indication:  
 List indication: \_\_\_\_\_

Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:  
 \_\_\_\_\_  
 \_\_\_\_\_

Member has a diagnosis of adult growth hormone deficiency

**\*The following documentation will be required for diagnosis of "growth hormone deficiency"**

- Biochemical evidence or other applicable testing supporting the diagnosis

Please select one of the following:

- Request is for a preferred agent
- Request is for a non-preferred agent with a product-specific indication:  
List indication: \_\_\_\_\_
- Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:  
\_\_\_\_\_  
\_\_\_\_\_

- Diagnosis of HIV-associated wasting or cachexia (Serostim only)

**\*The following documentation will be required for diagnosis of "HIV- associated wasting or cachexia"**

- Quantitative measurement of lean body mass using DEXA (dual energy X-ray absorptiometry) or BIA (bioelectric impedance analysis)
- Documentation of involuntary weight loss of >10% of baseline total body weight OR body cell mass <30% for initial approval

Member's current AIDS/HIV anti-retroviral regimen: \_\_\_\_\_

Member has tried and failed one of the following (include trial date, dose, frequency, duration, reason for failure):  Dronabinol  Megestrol  Anabolic Steroids  None  Other (please explain)

\_\_\_\_\_  
\_\_\_\_\_

**For ALL indications\*** – Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy  Yes  No

I, \_\_\_\_\_ hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

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

Please complete the following:

<b>Current:</b>	height: _____ (inches)	weight: _____ (lbs)
<b>3 months prior:</b>	height: _____ (inches)	weight: _____ (lbs)
<b>6 months prior:</b>	height: _____ (inches)	weight: _____ (lbs)

**SOMATROPIN AGENTS – Reauthorization**

**Please select one of the following:**

- Member has previously been transitioned from pediatric growth hormone therapy

Please select one of the following:

- Request is for a preferred agent
- Request is for a non-preferred agent with a product-specific indication:  
List indication: \_\_\_\_\_
- Prescriber would like to utilize a non-preferred agent over preferred agent based on the following

medical justification:

\_\_\_\_\_  
\_\_\_\_\_

- Member has a diagnosis of adult growth hormone deficiency and is continuing growth hormone

Please select one of the following:

- Request is for a preferred agent  
 Request is for a non-preferred agent with a product-specific indication:

List indication: \_\_\_\_\_

- Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:

\_\_\_\_\_  
\_\_\_\_\_

- Member has a diagnosis of HIV-associated wasting or cachexia and is continuing growth hormone therapy

- Member's current AIDS/HIV anti-retroviral regimen: \_\_\_\_\_
- Member has demonstrated an increase in total body weight or lean body mass from treatment baseline (**documentation required**)

**For ALL indications\*** – Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy  Yes  No

I, \_\_\_\_\_ hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

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

Please complete the following:

**Current:** height: \_\_\_\_\_ (inches) weight: \_\_\_\_\_ (lbs)

**3 months prior:** height: \_\_\_\_\_ (inches) weight: \_\_\_\_\_ (lbs)

**6 months prior:** height: \_\_\_\_\_ (inches) weight: \_\_\_\_\_ (lbs)

### SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Initial Authorization

Diagnosis of growth failure due to growth hormone deficiency  Yes  No

**\*The following documentation will be required for diagnosis of “adult growth hormone deficiency”**

- Biochemical evidence or other applicable testing supporting the diagnosis

Member is 18 years of age or older  Yes  No

Trial and failure of at least ONE preferred somatropin product  Yes  No

- If yes, please provide chart documentation or dates of use \_\_\_\_\_
- If no, please provide medical justification as to why the available preferred somatropin agent(s) are unsuitable for use:  
\_\_\_\_\_

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy  Yes  No

I, \_\_\_\_\_ hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.

Prescriber Signature: \_\_\_\_\_

### SKYTROFA (LONAPEGSSOMATROPIN-TCGD) – Reauthorization

Member is 18 years of age or older  Yes  No

Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate  Yes  No

I, \_\_\_\_\_ hereby attest that I continue to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: \_\_\_\_\_

### SOGROYA (SOMAPACITAN) – Initial Authorization

Diagnosis of adult growth hormone deficiency  Yes  No

**\*The following documentation will be required for diagnosis of “adult growth hormone deficiency”**

- Biochemical evidence or other applicable testing supporting the diagnosis

Member is 18 years of age or older  Yes  No

Please select one of the following:

- Trial and failure of Skytrofa (lonapegsomatropin) (supported by claims history or chart documentation)
- Prescriber would like to utilize a Sogroya (somapacitan) over Skytrofa (lonapegsomatropin) based on the following medical justification:

\_\_\_\_\_  
\_\_\_\_\_

Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy  Yes  No

I, \_\_\_\_\_ hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: \_\_\_\_\_

**SOGROYA (SOMAPACITAN) – Reauthorization**

Member is 18 years of age or older  Yes  No

Prescriber attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate  Yes  No

**I, \_\_\_\_\_ hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.**

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

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