Human Growth Hormone – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Endocrinologist ☐ Gastroenterologist ☐ HIV specialist
   ☐ Other. Specify: _____

3. If request is non-preferred, has patient had treatment with one or more preferred growth hormone medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication and duration of trial:

   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____

   ☐ No. Explain why a preferred product(s) has not been tried (i.e., preferred product(s) is not FDA approved for the requested indication): _____

4. What is patient weight?
   Baseline weight (pre-treatment): _____kg Date taken: _____
   Current weight: _____kg Date taken: _____

5. What is patient's height?
   Baseline height (pre-treatment): _____kg Date taken: _____
   Current height: _____ Date taken: _____

6. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Growth Hormone Deficiency in Children and Adolescents, <18 years old (questions 7-9)
   ☐ Growth Hormone Deficiency in Adults, 18 or older (questions 10 – 11)
   ☐ HIV/AIDS associated wasting or cachexia (questions 13 - 15)
   ☐ Short bowel syndrome (question 12)
   ☐ Other. Specify: _____

For Growth Hormone Therapy in Children and Adolescents (<18 years old)

United Healthcare Community Plan

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7. Indicate all that apply:
   - ☐ Patient's epiphyses are not closed (as confirmed by radiograph of the wrist and hand)
   - ☐ Patient has not reached final height

8. Indicate patient diagnosis and answer associated questions:
   - ☐ Prader-Willi Syndrome

   - ☐ Short stature associated with chronic renal insufficiency:
     - Is dialysis or a glomerular filtration rate (GFR) less than 60 ml/min/1.73m^2? ☐ Yes ☐ No
     - Is height below the 5th percentile for age and sex? ☐ Yes ☐ No
     - Is growth velocity is below the 25th percentile for age and sex for a minimum of 1 year? ☐ Yes ☐ No

   - ☐ Short stature associated with Turner Syndrome, Noonan Syndrome, or SHOX gene deficiency:
     - Is height below the 10th percentile for age and sex? ☐ Yes ☐ No

   - ☐ Growth Hormone Deficiency (GHD):
     - Does the patient have congenital GHD represented by acute hypoglycemia with low serum growth hormone levels? ☐ Yes ☐ No
     - Is height below the 3rd percentile (more than 2SDs for age and sex)? ☐ Yes ☐ No
     - Is height below the 5th percentile for age and sex with a growth velocity below the 25th percentile for a minimum of 1 year? ☐ Yes ☐ No
     - Does patient meet one of the following?:
       - ☐ At least two growth hormone stimulation tests less than reference range
       - ☐ At least one growth hormone stimulation test less than reference range and IGF-1 and IGFBP-3 are below normal
       - ☐ IGF-1 and IGFBP-3 are severely low (<-2 SD) with delayed bone age
       - ☐ GHD with additional pituitary hormone deficiencies

   - ☐ Idiopathic short stature or growth failure in children born small for gestational age (SGA):
     - Does height remain more than 2.25 SD below the mean age and gender at two years of age? ☐ Yes ☐ No
     - Is adult height, based on bone age, expected to be below the normal range (less than 63 inches for males and 59 inches for females)? ☐ Yes ☐ No
     - Does provider attest risks and benefits of growth hormone treatment have been discussed with patient and patient's guardian(s)? ☐ Yes ☐ No

9. **For continuation of therapy:** Has patient shown a response to growth hormone therapy (i.e., increase in height, increase in height velocity)? ☐ Yes ☐ No

For Growth Hormone Deficiency (18 or older)

10. Indicate if patient has any of the following (check all that apply):
    - ☐ Documentation of three or more pituitary hormone deficiencies (e.g. TSH, ACTH, gonadotropins, ADH, etc.) with a low IGF-1 level (<-2 standard deviation score)
    - ☐ Documentation of childhood onset GHD or GHD due to pituitary disease, hypothalamic disease, pituitary surgery, cranial radiation therapy, traumatic brain injury, or other condition affecting pituitary function

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☐ Documented clinical features of GHD, including but not limited to osteopenia, increased cardiovascular risk, or decreased quality of life
☐ Low IGF-1 level (<0 standard deviation score)
☐ A subnormal response to a provocative growth hormone (GH) stimulation test defined by(check all that apply):
- ☐ Macimorelin test - ≤2.8 ng/mL
- ☐ Insulin tolerance test (ITT) -≤5 ng/mL
- ☐ Glucagon-stimulation test (GST) - ≤ 3 ng/mL

11. **For continuation of therapy:** Has patient shown clinical benefits from growth hormone replacement as assessed by one of the following:
    - ☐ Normalization of insulin-like growth factor I (IGF-I)
    - ☐ Improvement in body composition (i.e. bone density increase, lipolysis changes)

For Short Bowel Syndrome:

12. Is patient currently on specialized nutritional support that has been protein, calorie, and fluid intake-optimized for at least two weeks? ☐ Yes ☐ No

For HIV/AIDS associated wasting or cachexia:

13. Has patient been treated with an appetite stimulant (dronabinol or megestrol) that has been ineffective, contraindicated, or not tolerated? ☐ Yes ☐ No

14. Has patient previously received somatropin therapy? ☐ Yes ☐ No
    If yes, how many weeks of somatropin therapy has patient received? _____Weeks

15. **For continuation of therapy:** Has patient shown clinical benefits by an increase in muscle mass and weight from growth hormone replacement? ☐ Yes ☐ No

CHART NOTES AND BASELINE ASSESMENTS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date