

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Eight separate Specialty Pharmacy Prior Authorization Request forms are included in this document:

- Form 1 - Growth Hormones used as treatment for Adults/Panhypopituitarism
- Form 2 - Growth Hormones used for the treatment of Chronic Renal Insufficiency
- Form 3 - Growth Hormones used for the Treatment of Neonatal Hypoglycemia
- Form 4 - Growth Hormones used as pediatric treatment
- Form 5 - Growth Hormones used as treatment for Prader Willi Syndrome
- Form 6 - Growth Hormones used as treatment for Small for Gestational Age or Idiopathic Short Stature
- Form 7 - Growth Hormones used as treatment for Short Bowel Syndrome
- Form 8 - Growth Hormones used as treatment for Turner Syndrome
- Form 9 - Growth Hormones used as treatment for Cachexia (HIV Wasting)

Prescribers (or their designees) should complete the form most applicable to the patient's diagnosis or reason for treatment. Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 1 - Growth Hormones used as treatment for Adults/Panhypopituitarism

Patient Information

Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information

Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

5. What is the specialty of the prescriber?

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Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Is the patient an adult? Y N

8. Have other causes of Growth Hormone Deficiency been ruled out? Y N

9. Has patient had at least 2 provocative tests? Y N
[If answer is yes, skip to question 13.]

10. Does patient have a pituitary or Central Nervous System (CNS) disorder? Y N

11. Please document the pituitary/CNS disorder.

12. Has patient had 1 provocative test?

13. Document baseline provocative test results.

- <5 mcg/L with Radio-immuno Assay (RIA) <3.5 mcg/L with Receptor Modulation Assay (RMA)
 <3 mcg/L during Hypoglycemia Other _____

14. Please document pre-treatment Insulin-like Growth Factor-1 (IGF-1) level. _____

15. What is the pre-treatment Insulin-like Growth Factor-1 (IGF-1) level?

- Within normal range for age and gender Low for age and gender High for age and gender
 No current IGF-1 level

16. Is the patient currently on Growth Hormone (GH) therapy? Y N
[If answer is no, no further questions.]

Only answer following questions if patient is currently on therapy.

17. Please document current Insulin-like Growth Factor-1 (IGF-1) level. _____

18. What is the current Insulin-like Growth Factor-1 (IGF-1) level?

- Within normal range for age and gender Low for age and gender High for age and gender
 No current IGF-1 level

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Form 2 - Growth Hormones used as treatment for Chronic Renal Insufficiency

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

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5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

8. Is the patient post kidney transplant? Y N

9. Are epiphyses still open? Y N

10. Is the patient currently on Growth Hormone therapy? Y N
[If the answer is yes, skip to question 14.]

11. What is the patient's Standard Deviation Score for age and gender? _____

12. What is the patient's adult height prediction? _____

13. Have metabolic abnormalities been stabilized? Y N

Only answer the following questions if patient is currently on therapy.

14. Please document the patient's **current** height. _____ cm, weight _____ kg and age _____

15. Is the patient growing by 2.5 cm/year or more? Y N

16. If patient is growing less than 2.5 cm/year, is there a clinical reason for the lack of efficacy? Y N

17. Please document reason: _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 3 - Growth Hormones used as treatment for Neonatal Hypoglycemia

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

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5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

8. Please document patient's Growth Hormone (GH) test results. _____

9. Is the patient currently on Growth Hormone therapy? Y N
[If the answer is yes, skip to question 12.]

10. Have other causes of hypoglycemia been ruled out or other treatments been ineffective? Y N

11. What is the patient's randomly assessed GH level (ng/mL)?

- < 20 ng/mL ≥ 20 ng/mL No random GH level

Only answer the following questions if patient is currently on therapy.

12. Is the patient euglycemic? Y N

13. If patient is not euglycemic, will therapy be adjusted to optimize efficacy? Y N

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 4 - Growth Hormones used for pediatric treatment

Patient Information

Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information

Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

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5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

8. Please document the patient's provocative test results. _____

9. Is the patient a neonate? Y N

10. Are epiphyses still open? Y N

11. Is the patient currently on Growth Hormone (GH) therapy? Y N
[If answer is yes, skip to question 24.]

12. Does the patient have delayed bone age? Y N

13. What is the patient's Standard Deviation Score for age and gender? _____

14. What is the patient's adult height prediction? _____

15. Have other causes of growth failure been ruled out? Y N

16. Has patient had at least 2 provocative tests? Y N
[If answer is yes, skip to question 19.]

17. Does patient have a pituitary or Central Nervous System (CNS) disorder? Y N

18. Please document the pituitary/CNS disorder.

19. What is the provocative test peak level? _____ ng/mL.

20. Does patient have results from Insulin-like Growth Factor 1/Insulin-like Growth Factor Binding Protein 3 (IGF-1/IGFBP3) measurements indicating Growth Hormone (GH) deficiency? Y N

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21. Please document IGF-1/IGFBP3) results.

- Less than 2 SD below the mean for age and gender
 Greater than 2 SD below the mean for age and gender

22. Does patient have clinical evidence of GHD? Y N

23. Please document clinical evidence: _____

Only answer the following questions if patient is currently on therapy.

18. Please document the patient's **current** height. _____ cm, weight _____ kg and age _____

19. Is the patient growing by 2.5 cm/year or more? Y N

20. If patient is growing less than 2.5 cm/year, is there a clinical reason for the lack of efficacy? Y N

21. Please document reason: _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 5 - Growth Hormones used as treatment for Prader Willi Syndrome

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

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5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

8. Has upper airway obstruction been ruled out via polysomnography? Y N

9. Please document polysomnography results. _____

10. Are epiphyses still open? Y N

11. Is the patient currently on Growth Hormone (GH) therapy? Y N
[If answer is yes, skip to question 14.]

12. What is the patient's Standard Deviation Score for age and gender? _____

13. What is the patient's adult height prediction? _____

Only answer the following questions if patient is currently on therapy.

14. Please document the patient's **current** height. _____ cm, weight _____ kg and age _____

15. Is the patient growing by 2.5 cm/year or more? Y N

16. If patient is growing less than 2.5 cm/year, is there a clinical reason for the lack of efficacy? Y N

17. Please document reason: _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 6 - Growth Hormones used as treatment for Small Gestational Age or Idiopathic Short Stature

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

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SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

8. Are epiphyses still open? Y N

Section A: Small for Gestational Age

9. What was the patient's gestational age at birth? _____ weeks _____ days

10. What was the patient's birth weight? _____ grams

11. What was the patient's birth weight or length for gestation age? _____ percentile

12. Is the patient currently on Growth Hormone (GH) therapy? Y N

13. Did patient fail to manifest catch-up growth by age two? Y N

14. Have other causes of growth failure been ruled out? Y N

Section B: Idiopathic Short Stature

15. Please document the patient's provocative test results. _____

16. Is the patient currently on Growth Hormone (GH) therapy? Y N

17. What is the patient's Standard Deviation Score for age and gender? _____

18. What is the patient's adult height prediction? _____

19. Based upon mid-parental height calculation, is the predicted height within normal range? Y N

20. Has pediatric GH deficiency been ruled out? Y N

21. Have other causes of growth failure been ruled out? Y N

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SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 6 - Growth Hormones used as treatment for Small Gestational Age or Idiopathic Short Stature

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

22. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

23. Is patient currently on Increlex? Y N

24. If patient is on Increlex, will the Increlex be discontinued? Y N

25. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

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SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

26. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

27. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

28. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

29. Are epiphyses still open? Y N

Section A: Small for Gestational Age

30. What was the patient's gestational age at birth? _____ weeks _____ days

31. What was the patient's birth weight? _____ grams

32. What was the patient's birth weight or length for gestation age? _____ percentile

33. Is the patient currently on Growth Hormone (GH) therapy? Y N

34. Did patient fail to manifest catch-up growth by age two? Y N

35. Have other causes of growth failure been ruled out? Y N

Section B: Idiopathic Short Stature

36. Please document the patient's provocative test results. _____

37. Is the patient currently on Growth Hormone (GH) therapy? Y N

38. What is the patient's Standard Deviation Score for age and gender? _____

39. What is the patient's adult height prediction? _____

40. Based upon mid-parental height calculation, is the predicted height within normal range? Y N

41. Has pediatric GH deficiency been ruled out? Y N

42. Have other causes of growth failure been ruled out? Y N

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 7 - Growth Hormones used as treatment for Short Bowel Syndrome

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Is the patient receiving specialized nutrition support? Y N

8. Is the patient currently on Growth Hormone (GH) therapy? Y N

9. If the patient is currently on GH therapy, how long has patient been on therapy for? _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 8 - Growth Hormones used for Turner Syndrome

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

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Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin AQ

Omnitrope Saizen Serostim Tev-Tropin Zorbtive

Other (specify): _____

2. Is patient currently on Increlex? Y N

3. If patient is on Increlex, will the Increlex be discontinued? Y N

4. Please check which of the following apply to the patient.

Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness

Evidence of pre-existing intracranial hypertension None of these apply.

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis?

- Pediatric growth hormone deficiency Neonatal hypoglycemia Turner syndrome
 Growth failure due to chronic renal insufficiency Small for gestational age Prader-Willi syndrome
 Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism
 HIV-related wasting/cachexia Short bowel syndrome
 Short stature homeobox-containing gene deficiency (SHOXD) Noonan syndrome
 Combination treatment with leuprolide in children with growth failure and advancing puberty
 Congenital adrenal hyperplasia Russell-Silver syndrome Cerebral palsy Septo-optic dysplasia
 Cystic fibrosis Other _____

7. Please document the patient's **pre-treatment** height. _____ cm, weight _____ kg and age _____

8. Is the diagnosis of Turner Syndrome confirmed by karyotyping? Y N

9. Please document patient's pre-treatment karyotype results. _____

10. Are epiphyses still open? Y N

11. Is the patient currently on Growth Hormone (GH) therapy? Y N
[If answer is yes, skip to question 15.]

12. What is the patient's Standard Deviation Score for age and gender? _____

13. What is the patient's adult height prediction? _____

14. Have other causes of growth failure been ruled out? Y N

Only answer the following questions if patient is currently on therapy.

22. Please document the patient's **current** height. _____ cm, weight _____ kg and age _____

23. Is the patient growing by 2.5 cm/year or more? Y N

24. If patient is growing less than 2.5 cm/year, is there a clinical reason for the lack of efficacy? Y N

25. Please document reason: _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 9 - Growth Hormones used as treatment for Cachexia (HIV Wasting)

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin
 Nutropin AQ Omnitrope Saizen Serostim Tev-Tropin Zorbive
 Other (specify): _____
2. Is patient currently on Increlex? Y N
3. If patient is on Increlex, will the Increlex be discontinued? Y N
4. Please check which of the following apply to the patient:
 Active or history of malignancy within the past 12 months Diabetic retinopathy Acute critical illness
 Evidence of pre-existing intracranial hypertension None of the above

GROWTH HORMONES

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

5. What is the specialty of the prescriber?

Endocrinology Gastroenterology Nephrology Infectious Disease Other: _____

6. What is the diagnosis? HIV related wasting/cachexia Other: _____

7. Please document patient's **pre-treatment** height _____ cm, weight _____ kg, Body Mass Index _____

8. Has the patient tried and achieved suboptimal response to alternative therapies? Y N

9. Please document alternative therapies that the patient has tried previously:

Marinol (dronabinol) Megace (megestrol) Other: _____

10. Have alternative causes of wasting been ruled out? Y N

11. Is the patient on anti-retroviral therapy? Y N

12. Is the patient currently on GH therapy? Y N

[If answer is no, no further questions are required.]

Only answer following questions if patient is currently on therapy.

13. How long has the patient been on GH therapy during current treatment round? _____ days

14. Please document patient's **current treatment** height _____ cm, weight _____ kg, Body Mass Index _____

15. Has the BMI improved/stabilized?

16. If the BMI has not improved, is there a clinical reason for lack of efficacy? Y N

17. Please document the reason: _____

18. How many rounds of Growth Hormone treatment has the patient had? Less than 2 2 or more

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::