

# GROWTH HORMONE



## (MEDICARE DETERMINATION)

### PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

**When this form is completed, please fax to Caremark at 1-888-836-0730.**

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- Does the medication meet the Medicare definition of a drug or biological (e.g., the drug appears in the latest edition of the USP-NF or American Dental Association guide to dental therapeutics)?  Y  N
- Is this an injectable formulation of the drug?  Y  N
- Is the patient enrolled in Medicare Part B?  Y  N
- Has this drug claim been submitted through Medicare Part B?  Y  N
- Was the drug claim denied by Medicare Part B?  Y  N
- Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)?  Y  N

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7. Is the drug delivered through intravenous administration?  Y  N
8. Is the drug administered through an implantable pump?  Y  N
9. Is the drug administered through an external pump?  Y  N
10. Is the drug included under a local coverage policy for the applicable Medicare DMERC?  Y  N
11. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting?  Y  N
12. Is the physician purchasing and providing the drug "incident to" physician services?  Y  N
13. Is the patient < 18 years of age?  Y  N
14. Does the patient have a height that is more than 2 standard deviations below the mean for normal children of the same age? (Equivalent to less than the 5<sup>th</sup> percentile for age)  Y  N
15. Does the patient have a height that is more than 1.5 standard deviations from the mid parental height?  Y  N
16. Has the patient experienced a poor growth velocity defined as more than 1 standard deviation below the mean for normal children of the same age (<5 cm per year)  Y  N
17. Does the patient have closed or fused epiphyses?  Y  N
18. Does the patient have the diagnosis of Turner's syndrome?  Y  N
19. Does the patient have the diagnosis of Prader-Willi Syndrome confirmed by appropriate genetic testing?  Y  N
20. Is the patient severely obese?  Y  N
21. Does the patient have a history of severe respiratory impairment or sleep apnea?  Y  N
22. Does the patient have the diagnosis of chronic renal insufficiency or chronic renal failure?  Y  N

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23. Has the patient received a renal transplant?  Y  N
24. At birth was the patient small for gestational age, defined as more than 2 standard deviations below normal for height and weight?  Y  N
25. Did the patient demonstrate catch-up growth by age 2?  Y  N
26. Does the patient have a delayed bone age for chronological age?  Y  N
27. Has the patient failed at least two growth hormone (GH) stimulation tests? (A failure is generally defined as a peak serum growth hormone value of less 10 mcg/L after GH stimulation)  Y  N
28. Has the patient been evaluated for other causes of growth failure? [e.g., drug induced (e.g., stimulants,steroids), skeletal disorders, malabsorption, chronic systemic disease, thyroid deficiency]  Y  N
29. Has the patient received at least 6 months of therapy through a Caremark pharmacy for benefit? [if the answer to this question is no, then no further questions]  Y  N
30. Has the patient been evaluated for continuation of therapy (i.e. thyroid function, glucose levels)?  Y  N
31. Has height of the patient increased in the past 6 months?  Y  N
32. Has the growth velocity of the patient improved since the initiation of the growth hormone therapy?  Y  N
33. Does the patient have a diagnosis of adult-onset of hypothalamic-pituitary disease?  Y  N
34. Does the patient have decreased hypothalamic-pituitary function due to a pituitary tumor?  Y  N
35. Does the patient have decreased hypothalamic-pituitary function due to pituitary surgical damage?  Y  N
36. Does the patient have decreased hypothalamic-pituitary function due to trauma?  Y  N
37. Does the patient have decreased hypothalamic-pituitary function due to cranial irradiation?  Y  N

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38. Does the patient have documented childhood-onset growth hormone deficiency?  Y  N
39. Has the patient been assessed for other endocrine disorders (i.e., thyroid deficiency)?  Y  N
40. Has the patient failed at least two growth hormone (GH) stimulation tests?  
[A failure is generally defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia]  Y  N
41. Will the physician evaluate the patient's serum insulin-like growth factor I during the first 3 months of therapy to evaluate the dose?  Y  N
42. Has the patient received at least 6 months of therapy through a Caremark pharmacy benefit?  Y  N
43. Has the patient been monitored for continuation of therapy(e.g., thyroid level, glucose level, lipid level, body measurements and x-ray)  Y  N
44. Has the physician evaluated the patient's serum insulin-like growth factor (IGF-1) to confirm the appropriateness of therapy?  Y  N
45. Has the patient had an improvement in symptoms and clinical features of growth hormone deficiency? (e.g. decreased in body fat, increased in bone density, better endurance and less fatigue)  Y  N

**Comments:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>  	<b>Date:</b>  
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