aetna™

Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Growth Hormone
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Chart notes that include weight, height, growth velocity and lab values (GH levels, IGF-1 / IGFBP-3), stim test results, bone age

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information							
Preferred Agent:	☐ Genotropin						
Non-Preferred Agents:	☐ Omnitrope	☐ Humatrope	☐ Saizen	☐ Serostim	☐ Tev-Tropin	☐ Norditropin	☐ Nutropin
	☐ Valtropin	☐ Zorbtive (somatropin)	☐ Zomacton	☐ Somatropin	☐ Other, please specify:		

Are there any contraindications to formulary medications? (if yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	What medication(s) have been tried and failed for this diagnosis? (please specify):			
What is the diagnosis ICD-10 Code?	Diagnosis:			
Directions for Use:	Strength:		Dosage Form:	
	Quantity:	Day Supply:	Duration of Therapy/Use:	

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Was there inability OR disability to use vial formulation (example: visual impairment)?	☐ Yes	☐ No	Was treatment for indication not supported by preferred Growth Hormone product?	☐ Yes	☐ No
Was there history of neonatal hypoglycemia associated with pituitary disease?	☐ Yes	☐ No	Was there history of irradiation, surgery OR trauma to hypothalamic-pituitary area?	☐ Yes	☐ No

Was there defined CNS pathology confirmed by MRI or CT?							☐ Yes	☐ No
☐ **Pediatric Growth Hormone Deficiency**								
Is height >2 standard deviations below mid parental height (projected height)?							☐ Yes	☐ No ☐ N/A
Is height >2.25 standard deviations below population mean for age and gender?							☐ Yes	☐ No ☐ N/A
Is growth velocity >2 standard deviations below population mean for age and gender?							☐ Yes	☐ No ☐ N/A
Is bone age compared to chronological age ≥ 2 standard deviations below mean for age and gender?							☐ Yes	☐ No ☐ N/A
Has member undergone 2 GH stimulation tests (for example, Arginine, Clonidine, Glucagon, Insulin, Levodopa, GhRh)?	☐ Yes	☐ No	☐ N/A	Were GH response values < 10 mcg/L?			☐Yes	☐ No ☐ N/A
Was ONE abnormal GH test enough for child with defined CNS pathology, multiple pituitary hormone deficiency, history of irradiation OR genetic defect affecting GH axis?							☐Yes	☐No ☐ N/A
Is member < 1 year of age AND IGF-1 or IGFBP-3 is below age AND gender adjusted normal range as provided by physician's lab?							☐Yes	☐No ☐ N/A
Are epiphyses open (confirming open growth plates in members who are over 12 years of age)?	☐ Yes	☐ No	☐ N/A	Were other pituitary hormone deficiencies ruled out (for example, hypothyroidism, chronic ischemic disease)?			☐ Yes	☐ No
☐ **Renewal ONLY**								
Did provider submit documentation for previous height, current height AND expected adult height goal?	☐ Yes	☐ No	Did height increase at least 2.5cm per year OR 4.5cm per year?				☐ Yes	☐ No
Was expected final height NOT achieved?	☐ Yes	☐ No	Is bone age <16 years for males OR <14 years for female?				☐ Yes	☐ No
Are growth (epiphyseal) plates still open?							☐ Yes	☐ No
☐ **Prader-Willi Syndrome**								
Is epiphyses open (confirmation of open growth plates in member > 12 years of age)?	☐Yes	☐No	☐ N/A	Is growth velocity >2 standard deviations below population mean for age AND gender?			☐Yes	☐No
☐ **Renewal ONLY**								
Is there documentation supporting positive response to therapy (for example, increase in total lean body mass, decrease in fat mass) OR above growth hormone renewal requirements are met?							☐ Yes	☐ No
☐ **Turner Syndrome**								
Is this request for a Female that is >2 years of age AND bone age is <14 years?	☐ Yes	☐ No	Is growth velocity >2 standard deviations below population mean for age and gender?				☐Yes	☐No
Are Epiphyses open (confirmation of open growth plates in patients over 12 years of age)?	☐Yes	☐No	☐N/A					
☐ **Noonan Syndrome**								
Is GV >2 standard deviation below population mean for age AND gender?	☐ Yes	☐ No	Is bone age compared to chronological age ≥2 standard deviations below mean for age AND gender?				☐ Yes	☐ No
Are epiphyses open (confirmation of open growth plates in member over 12 years of age)?	☐ Yes	☐ No	☐ N/A					
☐ **Short Stature with SHOX Deficiency**								
Was diagnosis confirmed by genetic testing?	☐ Yes	☐ No	Is bone age compared to chronological age ≥2 standard deviations below mean for age AND gender?				☐ Yes	☐ No
Epiphyses are open (confirmation of open growth plates in patients over 12 years of age)?	☐ Yes	☐ No	Is GV >2 standard deviations below population mean for age AND gender?				☐ Yes	☐ No
☐ **Growth Failure with Chronic Renal Insufficiency OR Chronic Kidney Disease Prior to Renal Transplantation**								
Prior to start with GH therapy, were the existing metabolic derangements such as malnutrition, zinc deficiency AND secondary hyperparathyroidism corrected?							☐ Yes	☐ No
Was bone age compared to chronological age ≥2 standard deviations below mean for age and gender?	☐ Yes	☐ No	Is growth velocity >2 standard deviations below population mean for age and gender?				☐ Yes	☐ No
☐ **Growth Failure in Children Small for Gestational Age**								
Did child fail to achieve catch up growth in first 24 months of life (by 2 years of age) using a 0-36-month growth chart?							☐ Yes	☐ No

Is member below the 3rd percentile for gestational age (>2 standard deviations below population mean) for birth weight AND length?	☐ Yes	☐ No	Did member height remain below 3rd percentile (> 2 standard deviations below population age AND gender)?	☐ Yes	☐ No
☐ **Renewal Request ONLY:**					
Did provider submit documentation for previous height, current height AND expected adult height goal?	☐ Yes	☐ No	Did height increase at least 2.5cm per year OR 4.5cm per year?	☐ Yes	☐ No
Was expected final height NOT achieved?	☐ Yes	☐ No	Is bone age <16 years for males OR <14 years for female?	☐ Yes	☐ No
Are growth (epiphyseal) plates still open?				☐ Yes	☐ No
☐ **Transition Phase Adolescent Members**					
Is adolescent between ages 10 to 19 as defined by World Health Organization?				☐ Yes	☐ No
Did member attain expected adult height?	☐ Yes	☐ No	Did bone radiograph show closed epiphyses?	☐ Yes	☐ No

Member is at high risk of GH? deficiency due to childhood-onset from ONE of the following:	☐ Hypothalamic-Pituitary structural defect or tumor	☐ At least 3 deficiencies of anterior pituitary hormones (FSH / LH, TSH, ACTH, Prolactin), pan-hypopituitarism	☐ Genetic cause of GH
Is IGF-1 below age AND gender adjusted normal range as provided by physician's lab?			☐ Yes ☐ No

☐ Member has stopped GH therapy for at least ONE month AND undergone ONE provocative GH stim test confirming transition phase GH deficiency AND ONE of the following peak values:	Insulin Tolerance Test: ☐ ≤5 ng/ml	Glucagon: ☐ ≤3 ng/mL	Arginine: ☐ ≤0.4 ng/mL
	Arginine + GHRH: ☐ ≤11 ng/mL if BMI is < 25 kg/m2 ☐ ≤8 ng/mL if BMI ≥25 and <30 kg/m2 ☐ ≤4 ng/mL if BMI ≥30 kg/m2		

☐ **Renewal ONLY**		
Is there documentation supporting positive response to therapy (for example, increase in total lean body mass, increased exercise capacity OR increased IGF-1 levels) AND documentation is submitted with request?	☐Yes	☒No
☐ **Adult Growth Hormone Deficiency**		
Did provider submit documentation supporting diagnosis, stim test results, and IGF-1 levels?	☐Yes	☐No

Is there a diagnosis of childhood-onset GHD?	☐Yes	☐No	Is there a diagnosis of adult-onset GHD?	☐Yes	☐No
Is there documentation supporting hormone deficiency is due to hypothalamic-pituitary disease from organic or known causes?	☐Yes	☐No	Was there 1 GH stim test confirming adult GH deficiency (insulin tolerance test, arginine+GHRH, glucagon, arginine)?	☐Yes	☐No

Member has ONE of the following peak value tests:	Insulin tolerance test: ☐ ≤5 ng/ml	Arginine+GHRH: ☐ ≤11 ng/mL if BMI is < 25 kg/m2 ☐ ≤8 ng/mL if BMI ≥25 and <30 kg/m2 ☐ ≤4 ng/mL if BMI ≥30 kg/m2	Glucagon: ☐ ≤3 ng/mL	Arginine: ☐ ≤0.4 ng/mL	Macimorelin: ☐ ≤2.8 ng/mL

Is there at least 3 deficiency of anterior pituitary hormones (FSH/LH, TSH, ACTH, Prolactin), pan-hypopituitarism?	☐Yes	☐No	Is IGF-1 below age AND gender adjusted normal range as provided by physician's lab?	☐Yes	☐No
☐ **Renewal ONLY**					
Is there documentation supporting positive response to therapy (for example, increase in total lean body mass, increased exercise capacity OR increased IGF-1 levels) AND documentation is submitted with request?				☐Yes	☐No
☐ **HIV-Associated Cachexia or Wasting**					

Is there documentation of BMI, weight, and ideal body weight prior to start of therapy and then after starting Serostim?	☐Yes	☐No	Is member on current use of anti-retroviral therapy?	☐Yes	☐No
Was there inadequate response, intolerable side effects, or contraindication to megestrol acetate or dronabinol?	☐Yes	☐No	Is the BMI <20 kg/m2 prior to starting Serostim?	☐ Yes	☐ No
Was there weight loss due to other causes such as depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with exception of Kaposi's sarcoma limited to skin or mucous membranes?				☐ Yes	☐ No
Member has unintentional weight loss of >10% over last 12 months or >5% over last 6 months?	☐Yes	☐No	Is weight <90% of the lower limit of ideal body weight?	☐ Yes	☐ No

☐ **Renewal ONLY**					
Is there documentation supporting positive response to therapy (BMI has improved or stabilized)?	☐Yes	☐No	Is member on current anti-retroviral therapy?	☐ Yes	☐ No
☐ **Short Bowel Syndrome**					
Is member currently receiving specialized nutrition support (IV parenteral nutrition, fluid AND micronutrient supplements)?	☐Yes	☐No	Was 4 weeks of treatment with Zorbtive previously received?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.