

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

Aetna Better Health*

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:				Height:			
								□ Male □ Female							
Member ID:				City:			S	State:				Weight:			
Prescribing Provider In	formation			1											
Provider Name (first & last): Specia					alty: NP				 יו# DE				A#		
Office Address: City:				Sta				ite: Zip				o Code:			
Office Contact: Office				Phone					Office Fax:						
Dispensing Pharmacy I	nformation														
Pharmacy Name:				Pharmacy Phone:					Pharmacy Fax:						
Requested Medication	Information			1											
Preferred Agent:	🗆 Genotropin														
-															
			_		•										
Non-Preferred	🗆 Omnitrope	🗆 Huma	atrope		aizen		erostim		□ Tev-		Norditr	opin	□ Nut	ropin	
Agents:		7				Somatropin		Tropin							
		□ Zorbt			omacton			pin	Other, please specify:						
		(somatr	opinj												
Are there any contraind	ications to formula	ry med	lication	is?				es	□ No		ew		Contir	uation	
(if yes, please specify):										re	quest		of ther	ару	
Medication request is N	OT for an FDA-		What	t medic	ation(s) ha	ave be	en tried	d and	failed fo	r this dia	gnosis	s? (ple	ease spe	cify):	
approved, or compendia	a-supported diagr	osis													
(circle one):															
Yes	No														
What is the diagnosis IC	D-10 Code?				Dia	gnosis	:								
<u> </u>											_				
Directions for Use:				Stren	igth:					Dosage	e Form	n:			
							Day Supply:			Duration of Therapy/Use:					
				Quan			.,	1.14.7				- - -14	,		
Turn-Around Time for I				•		I									
Standard – (24 hour	-		-	-	urs for stai					-	n life, h	nealth	or abilit	y to	
	rega	ain max	imum f	functio	n, you can	ask fo	ranex	pedi	ted decis	ion.					
	Sigi	nature:													
Clinical Information		_													
Was there inability OR d	isability to use via	□ Ye	es [⊐ No	Was trea	atmen	tment for indication			on not supported by			∃ Yes	□ No	
formulation (example: v	isual				preferre	d Grov	Growth Hormone prod								
impairment)?															
Was there history of neo		□ Ye	es [⊐ No	Was there history of irradiation, surgery OR trauma					□ No					
hypoglycemia associate	ed with pituitary				to hypothalamic-pituitary area?										
disease?															

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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)?										□ 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 Image: Stress of the stimulation tests (for example, Arginine, Clonidine, Glucagon, Insulin, Levodopa, GhRh)? Image: Stress of the stress of									□Yes	□ No	□ N/A	
Was ONE abnormal GH test enough for child with defined CNS pathology, multiple pituitary hormone										□Yes	□No	□ N/A
deficiency, history of irradiation OR genetic defect affecting GH axis?												
Is member < 1 year of age AND IGF-1 or IGFBP-3 is below age AND gender adjusted normal range as									□Yes	□No	□ N/A	
provided by physician's lab?												
Are epiphyses open (confirming \Box									□ Yes		No	
open growth plates in members			N/	Ά				(for exam				
who are over 12 years of age)?							n, chro	nic ischem	ic			
					dise	ase)?						
Renewal ONLY					1						1	
Did provider submit documentation for pr			ΠY	'es			-	ncrease at l		n per	□ Yes	🗆 No
height, current height AND expected adul goal?		ht						cm per yea				
Was expected final height NOT achieved?)R <14	□ Yes	□ No		
Are growth (epiphyseal) plates still open?										□ Yes	□ No	
Prader-Willi Syndrome												
Is epiphyses open (confirmation of open]Yes	□N	0		Is growt	h veloo	city >2 star	dard devia	ations	□Yes	□No
growth plates in member > 12 years of N/A below population mean for age AND									2			
age)? gender?												
				Renewal ONLY								
Renewal ONLY			1			1					ľ	
						-		in total lea	n body mas	SS,	□ Yes	□ No
Renewal ONLY Is there documentation supporting positive						-		in total lea	n body mas	6S,	□ Yes	□ No
Renewal ONLY Is there documentation supporting positiv decrease in fat mass) OR above growth here	ormor			equir	rement	s are met?	,	in total lear			□ Yes	□ No
Renewal ONLY Is there documentation supporting positiv decrease in fat mass) OR above growth he Turner Syndrome	ormor	e rene	walr	equir	rement Is gro	s are met? wth veloci	ty >2 st		viations be			
Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here Turner Syndrome Is this request for a Female that is >2	ormor	ne rene Yes	wal r	equii	rement Is gro popul	s are met? wth veloci ation mea	ty >2 st	tandard de ge and gen	viations be			
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Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here Turner Syndrome Is this request for a Female that is >2 years of age AND bone age is <14 years?	grow	Yes Yes Yh plat Yes	ewal r	equin lo patie	Is gro popul ents ov Is bor stand gende	s are met? wth velocit ation mea er 12 years e age com ard deviati er?	ty >2 si n for ag of npared ons be	tandard de ge and gen □Yes to chronol	viations be der? □No ogical age	elow □N/A ≥2	□Yes	□No
 Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here Turner Syndrome Is this request for a Female that is >2 years of age AND bone age is <14 years? Are Epiphyses open (confirmation of oper age)? Noonan Syndrome Is GV >2 standard deviation below population mean for age AND gender? Are epiphyses open (confirmation of oper age)? 	grow grow	Yes Yes Yh plat Yes	ewal r	equin lo patie	Is gro popul ents ov Is bor stand gende	s are met? wth velocit ation mea er 12 years e age com ard deviati er?	ty >2 si n for ag of npared ons be	tandard de ge and gen DYes to chronol	viations be der? □No ogical age for age AN	elow □N/A ≥2 D	□Yes	□No
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□ Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here documentation supporting positive decrease in fat mass) OR above growth here are synchrome □ Turner Syndrome Is this request for a Female that is >2 years of age AND bone age is <14 years?	grow grow	Yes Yes Yes Yes Is bo belo D Ye	wal r n	lo patie	Is gro popul ents ov Is bor stand gende bor age lo Is n	s are met? wth velocit ation mea er 12 years e age com ard deviati er? er 12 years ed to chror AND gend s GV >2 sta nean for ag	ty >2 st n for ag of npared ons be s of nologic er? ndard ge ANE	tandard de ge and gen UYes to chronol elow mean UYes al age ≥2 s deviations O gender?	viations be der? DNo ogical age for age AN DNO tandard de below pop	elow □N/A ≥2 ID □N/A eviations	□Yes □Yes	□ No □ No □ No
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□ Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here □ Turner Syndrome Is this request for a Female that is >2 years of age AND bone age is <14 years?	grow grow grow I No ge)? nsuff isting i? age ≥	rth plat Yes Th plat Yes Is be belo D Ye iciency metab	wal r es in es in one ag w me es y OR	equin lo patie lo men ge ccc ean fo can fo Chro	rement Is gro popul ents ov Is bor stand gende ber ov or age lo Is nonic Kie	s are met? wth velocit ation mea er 12 years e age com ard deviati er? er 12 years ed to chror AND gend s GV >2 sta hean for ag Iney Dise nts such as	ty >2 st n for ag of npared ons be s of nologic er? ndard ge ANE ase Pri s malm	tandard de ge and gen □Yes to chronol elow mean □ Yes al age ≥2 s deviations D gender? ior to Rena utrition, zin	viations be der? No ogical age for age AN No tandard de below pop I Transpla c deficience andard de	elow □N/A ≥2 D N/A wiations oulation ntation cy AND viations	□Yes □Yes □Yes □Yes	 No No No No No No No
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Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here Turner Syndrome Is this request for a Female that is >2 years of age AND bone age is <14 years?	grow grow grow l No suge)? nsuffi age 2 age 2 nd	rth plat Yes th plat Yes th plat Is bo belo D Ye metab	wal r wal r r r r r r r r r r r r r r	equin lo patie lo mem ge cc ean fo chro derar	Is gro popul ents ov Is bor stand gende bor age lo Is n ponic Kie	s are met? wth velocit ation mea er 12 years e age com ard deviati er? er 12 years ed to chror AND gend s GV >2 sta hean for ag Iney Dise nts such as	ty >2 si of opared ons be s of aologic er? Indard ge ANE ase Pri s malne wth ve popul	tandard de ge and gen □Yes to chronol elow mean □ Yes al age ≥2 s deviations D gender? ior to Rena utrition, zin	viations be der? No ogical age for age AN No tandard de below pop I Transpla c deficience andard de	elow □N/A ≥2 D N/A wiations oulation ntation cy AND viations	□Yes □Yes □Yes □Yes	 No No No No No No No No No
Renewal ONLY Is there documentation supporting positive decrease in fat mass) OR above growth here Turner Syndrome Is this request for a Female that is >2 years of age AND bone age is <14 years?	grow grow grow l No sting isting i? age 2 age 2 age 2 age 2 age 2	rth plat Yes Th plat Yes th plat Is be belo belo belo iciency metab	wal r	equin lo patie do men ge ccc ean fo chro derar	rement Is gro popul ents ov Is bor stand gende bor age lo Is nompare or age lo Is nompare or age	s are met? wth velocit ation mean ation mean ation mean are age com- ard deviation ard deviation are 12 years er 12 years er 12 years ato chror AND gend GV >2 stante nean for age ants such as o Is groon below gende	ty >2 st of of opared ons be s of ons de s of ons de as of as a print s malne wth ve popul	tandard de ge and gen □Yes to chronol elow mean □Yes al age ≥2 s deviations 0 gender? for to Rena utrition, zin locity >2 st ation mean	viations be der? No ogical age for age AN I No tandard de below pop I Transpla c deficience andard de n for age an	elow □N/A ≥2 D □N/A eviations oulation ntation cy AND viations nd	□Yes □Yes □Yes □Yes	 No No No No No No No No No

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Is member below the 3rd percentile for gestational age (>2 standard deviations below population mean) for birth weight AND length?		nal [□ Yes		ре	ercentile (:	> 2 sta	nt remain be ndard devia ND gender)?	tions be		□ Yes	□ No
Renewal Request O							•	<u> </u>				
Did provider submit documentation for previous height, current height AND expected adult height goal?						Did height increase at least 2.5cm year OR 4.5cm per year?				r	□ Yes	□ No
Was expected final height NOT achieved?						Is bone age <16 years for males OR <14 years for female?					□ Yes	□ No
Are growth (epiphyseal) plates still open?					,			□ Yes	□ No			
□ Transition Phase Ad	olescent Members											
Is adolescent between ag	l Health	Orga	anization	?					□ Yes	□ No		
Did member attain expected adult height?			□ No		Did bone radiograph			show closed epiphyses?			□ Yes	□ No
Member is at high risk of GH?Image: Hypothalamic-Pdeficiency due to childhood- onset from ONE of the following:structural defect o				pit AC	□ At least 3 deficiencie pituitary hormones (FS ACTH, Prolactin), pan-			_H, TSH,		Gene	tic cause o	of GH
Is IGF-1 below age AND g	ender adjusted norma	l range a	s provid	led b	y physici	an's lab?					□ Yes	□ No
Member has stopped GH therapy for at least ONE m undergone ONE provocative GH stim test confirming phase GH deficiency AND ONE of the following peak				ansition <u>Test</u> : □ ≤3 ng/mL					rginine: ≤0.4 ng/mL			
phase an achievery		ing pea	R values			e + GHRF	4:					
					-			: 25 kg/m2				
				□ ≤8 n	g/mL if Bl	MI ≥25	and <30 kg	ı/m2				
			□ ≤4 n	g/mL if Bl	MI ≥30) kg/m2						
Renewal ONLY						1						
Is there documentation supporting positive response to the					-			-	mass,		□Yes	⊠No
increased exercise capacity OR increased IGF-1 levels) AND documentation is submitted with request? Adult Growth Hormone Deficiency												
Did provider submit docu	-	diagnosi	e etim t	ost r	osulte ar	d IGE-1 la	vels?				□Yes	□No
Is there a diagnosis of chi		□Yes	s ⊡No		-					□Yes	□No	
Is there documentation s		□Yes	s □No		Was there 1 GH stim test confirming adult GH deficiency (insulin tolerance test,						□Yes	□No
	deficiency is due to hypothalamic-pituitary				deficienc	y (insulin						
disease from organic or known causes?					orainina			n arginina)	0			
Mombor bas ONE of		Arain			arginine+	GHRH, gl	-	on, arginine) [,]		20.	Macin	orolin:
Member has ONE of the following peak	Insulin tolerance	-	nine+GH	RH:			GI	lucagon:	Arginiı			orelin:
the following peak	Insulin tolerance test:	□ ≤11	ng/mL	RH: if BN	11 is < 25	kg/m2	GI	-	Arginiı □ ≤0.4	ł		norelin: ng/mL
	Insulin tolerance	□ ≤11 □ ≤8	l ng/mL ng/mL i	RH: if BN		kg/m2	GI	lucagon:	Arginiı	ł		
the following peak	Insulin tolerance test:	□ ≤11 □ ≤8 kg/m	l ng/mL ng/mL i n2	RH: if BN if BM	11 is < 25	kg/m2 I <30	GI	lucagon:	Arginiı □ ≤0.4	ł		
the following peak	Insulin tolerance test: □ ≤5 ng/ml	□ ≤11 □ ≤8 kg/m □ ≤4	Ing/mL ng/mLi ng/mLi	RH: if BM if BM	/I is < 25 II ≥25 and II ≥30 kg/	kg/m2 1 <30 ′m2	GI	lucagon:	Arginiı □ ≤0.4 ng/mL	l -		
the following peak value tests:	Insulin tolerance test: □ ≤5 ng/ml ncy of anterior pituitary	□ ≤11 □ ≤8 kg/m □ ≤4	Ing/mL ng/mLi ng/mLi	RH: if BM if BM if BM	1 is < 25 ≥25 and ≥30 kg/ s GF-1 b	kg/m2 I <30 ′m2 elow age	GI GI AND g	lucagon: ≤3 ng/mL	Arginiı □ ≤0.4 ng/mL	l -	□ ≤2.8	ng/mL
the following peak value tests: Is there at least 3 deficien	Insulin tolerance test: □ ≤5 ng/ml ncy of anterior pituitary	□ ≤11 □ ≤8 kg/m □ ≤4	Ing/mL ng/mLi ng/mLi	RH: if BM if BM if BM	1 is < 25 ≥25 and ≥30 kg/ s GF-1 b	kg/m2 I <30 ′m2 elow age	GI GI AND g	lucagon: ≤3 ng/mL gender adjus	Arginiı □ ≤0.4 ng/mL	l -	□ ≤2.8	ng/mL
the following peak value tests: Is there at least 3 deficien hormones (FSH/LH, TSH, pan-hypopituitarism?	Insulin tolerance test: □ ≤5 ng/ml ncy of anterior pituitary ACTH, Prolactin),	□ ≤11 □ ≤8 kg/m □ ≤4 □Yes	Ing/mL ng/mLi n2 ng/mLi	RH: if BM if BM o	II is < 25 II ≥25 and II ≥30 kg/ Is IGF-1 b range as	kg/m2 I <30 /m2 elow age provided	AND g	lucagon: ≤3 ng/mL gender adjus ysician's lab	Arginiı □ ≤0.4 ng/mL sted nor ?	l -	□ ≤2.8	ng/mL
the following peak value tests: Is there at least 3 deficien hormones (FSH/LH, TSH, pan-hypopituitarism? Renewal ONLY Is there documentation set	Insulin tolerance test: □ ≤5 ng/ml ncy of anterior pituitary ACTH, Prolactin), upporting positive resp	□ ≤11 □ ≤8 kg/m □ ≤4 □ Yes	Ing/mL ng/mL i ng/mL i s DN therapy	RH: if BM if BM o (for	II is < 25 II ≥25 and II ≥30 kg/ Is IGF-1 b range as example,	kg/m2 I <30 /m2 elow age provided increase	AND g	lucagon: ≤3 ng/mL gender adjus ysician's lab	Arginiı □ ≤0.4 ng/mL sted nor ?	l -	□ ≤2.8	ng/mL
the following peak value tests: Is there at least 3 deficien hormones (FSH/LH, TSH, pan-hypopituitarism? Renewal ONLY Is there documentation so increased exercise capac	Insulin tolerance test: □ ≤5 ng/ml ncy of anterior pituitary ACTH, Prolactin), upporting positive resp city OR increased IGF-	□ ≤11 □ ≤8 kg/m □ ≤4 □ Yes	Ing/mL ng/mL i ng/mL i s DN therapy	RH: if BM if BM o (for	II is < 25 II ≥25 and II ≥30 kg/ Is IGF-1 b range as example,	kg/m2 I <30 /m2 elow age provided increase	AND g	lucagon: ≤3 ng/mL gender adjus ysician's lab	Arginiı □ ≤0.4 ng/mL sted nor ?	l -	□ ≤2.8 □Yes	ng/mL □No
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Effective: 10/01/2020 C18957-A IL 06-2020

Renewal ONLY									
	□Yes	□No	Is member on current anti-retroviral	□ Yes	□ No				
to therapy (BMI has improved or stabilized)?			therapy?	103					
Short Bowel Syndrome									
Is member currently receiving specialized nutrition	□Yes		Was 4 weeks of treatment with Zorbtive	□ Yes	□ No				
		s □No							
support (IV parenteral nutrition, fluid AND micronutrient			previously received?						
supplements)?									
Additional information the prescribing provider feels i	s impor	tant to this	s review. Please specify below or subm	t medical	records				
Signature affirms that information given on this form is	s true a	nd accura	te and reflects office notes.						
Prescribing Provider's Signature:			Date:						
Please note: Incomplet	e form	s or forms	without the chart notes will be returned						

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