Aetna Better Health® of Virginia

Growth Hormone Request Form

Fax back to 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

Is the Drug Prescribed by or in Consultation with a Specialty?

☐ Endocrinologist ☐ Nephrologist

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Quantity per Day: _____

All Growth Hormone medications require the submission of a Clinical Service Authorization

Preferred Medications:

☐ **Genotropin®** ☐ **Norditropin FlexPro®**

Non-Preferred Medications:

☐ *Humatrope® cartridge/vial* ☐ *Nutropin AQ® NuSpin®* ☐ *Nutropin AQ® cartridge/vial*

☐ *Omnitrope® cartridge/vial* ☐ *Saizen® cartridge/vial* ☐ *Serostim® vial*

☐ *Skytrofa™ Syringe* ☐ *Zomacton® vial* ☐ *Zorbtive® vial*

If requesting a non-preferred agent, please document why a preferred agent cannot be used:

_____

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

CRITERIA

1. What is the diagnosis?
   - ☐ Idiopathic short stature (ISS)
   - ☐ Noonan syndrome (NS)
   - ☐ SHOX deficiency (SHOXD)
   - ☐ Adult GH deficiency
   - ☐ Prader Willi syndrome (PWS)
   - ☐ Chronic renal insufficiency
   - ☐ Other: _____
   - ☐ Pediatric growth hormone (GH) deficiency
   - ☐ Familial short stature
   - ☐ Small for gestational age (SGA)
   - ☐ Turner syndrome (TS)
   - ☐ Short bowel syndrome (SBS), ***skip to diagnosis section***
   - ☐ Pediatric chronic kidney disease, ***skip to diagnosis section***
2. Is this request for a new start, restart (re-initiation) or continuation of Growth Hormone (GH) therapy?
   ☐ New start, ***skip to diagnosis section*** ☐ Restart, ***skip to diagnosis section*** ☐ Continuation
3. Is the member's growth velocity at least 2 cm per year while on GH therapy?
   ☐ Yes ☐ No
   Action Required: *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*
4. Are the growth plates open?
   ☐ Yes ☐ No
5. What is the member's current height? Age: Years _____ Months _____ Height: _____ inches
   Action Required: *Please attach documentation from the medical record of current height.*

DIAGNOSIS AND MEDICAL INFORMATION

Complete the Following Section(s) Based on the Member's Diagnosis. Complete All That Apply:

Section A: All Pediatric Indications

6. What is the member's pretreatment height and age?
   Age: Years _____ Months _____ Height: _____ inches
   Action Required: *Please attach documentation from the medical record showing pretreatment height and age at measurement.*
7. Which of the following criteria does the member's pretreatment height meet?
   - ☐ Greater than or equal to 2.25 standard deviations (SD) below the mean for age and gender
   - ☐ Greater than or equal to 2 standard deviations (SD) below the mean for age and gender
8. What is the member's pretreatment growth velocity?
   - ☐ Greater than 1 standard deviation (SD) below the mean for age and gender
   - ☐ 1 SD below the mean for age and gender

   Action Required: *Please attach documentation from the medical record showing either.*
   - ☐ At least 2 heights measured by an endocrinologist at least 6 months apart (data for at least 1 year)
   - ☐ At least 4 heights measured by a primary care physician at least 6 months apart (data for at least 2 years)

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

Section B: Pediatric GH Deficiency

9. Did the member have a GH response of less than 10 ng/mL (or otherwise abnormal as determined by the lab) of at least 2 GH stimulation tests LFTs?
   ☐ Yes ☐ No
   Action Required: *If YES, please attach documentation of stimulation test results.*
10. Did member have a GH response of less than 15 ng/mL on at least 1 GH stimulation test?
    ☐ Yes ☐ No
    Action Required: *Please attach documentation of GH stimulation test result. If YES, indicate results.*
11. Does the member have a defined CNS pathology, history of cranial irradiation or genetic condition associated GH deficiency?
    ☐ Yes ☐ No
12. Does the member have both IGF-1 and IGFBP-3 levels below normal for age and gender?
    ☐ Yes ☐ No
    Action Required: *If YES, please attach documentation from the medical record showing IGF-1 and IGFBP-3 levels below normal.*
13. Does the member have 2 or more documented pituitary hormone deficiencies other than GH?
    ☐ Yes ☐ No
14. Did the member have an abnormally low GH level in association with neonatal hypoglycemia?
    ☐ Yes ☐ No
    Action Required: *If YES, please attach documentation of GH level.*

Section C: Pediatric Chronic Kidney Disease/ Chronic Renal Insufficiencies

15. Does the member have any of the following? Indicate any/all the apply:
    ☐ Creatinine clearance of 75 mL/min/1.73 m2 or less ☐ Dialysis dependency
    ☐ Serum creatinine greater than 3.0 g/dL ☐ None of the above

Section D: Pediatric Chronic Kidney Disease

16. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?
    ☐ New start, *no further questions* ☐ Restart ☐ Continuation
17. Was GH therapy previously approved for this member?
    ☐ Yes ☐ No
18. What is the member's current height in inches? _____
    Action Required: *Please attach documentation from the medical record of current height.*
    If Restart, no further questions.
19. Is the member's growth velocity at least 2 cm per year while on GH therapy?
    ☐ Yes ☐ No
    Action Required: *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

Section E: Adult GH Deficiency

20. Does the member have irreversible hypothalamic/pituitary structural lesions or ablation?
    ☐ Yes ☐ No ***If YES, no further questions.***
21. Does the member have a defect in GH synthesis?
    ☐ Yes ☐ No ***If YES, no further questions.***
22. Did the member have GH deficiency diagnosed during childhood?
    ☐ Yes ☐ No
23. Does the member have 3 or more pituitary hormone deficiencies?
    ☐ Yes ☐ No
24. Was the member retested for GH deficiency after an at least 1-month break in GH therapy?
    ☐ Yes ☐ No
25. Which of the following pharmacologic agents was used in a GH stimulation test to measure peak GH levels?
    ☐ Insulin ☐ Clonidine ☐ Levodopa ☐ Glucagon ☐ Arginine
    ☐ GH stimulation test not performed ☐ Other: _____
    Action Required: *Please attach documentation showing the results of GH stimulation test.*
26. Indicate the peak GH level: _____ ng/mL
27. Is the pretreatment IGF-1 level below the laboratory's range of normal?
    ☐ Yes ☐ No
    Action Required: *Please attach documentation from the medical record showing the member's pretreatment IGF-1 level.*

Section F: Short Bowel Syndrome

28. Is the member receiving specialized nutritional support?
    ☐ Yes ☐ No
29. Will GH be used in conjunction with optimal management of short bowel syndrome?
    ☐ Yes ☐ No
30. How many months of GH therapy has the member received? _____ months ☐ Not Applicable/New Start

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.