

**Growth Hormones (GHs) PreDetermination of Medical Benefits**

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type

Request Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Initial Authorization Request       Re-Authorization Request; List Prior Auth Ref #: \_\_\_\_\_

Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)       Yes     No

| 1. PATIENT INFORMATION   |                    |                       |                               |
|--------------------------|--------------------|-----------------------|-------------------------------|
| Patient Last Name        | Patient First Name | Patient ID Number     | Patient DOB<br>/ /            |
| Address                  | City               | State / Zip Code<br>/ | Contact Phone Number<br>( ) - |
| Date of Diagnosis<br>/ / | Primary Diagnosis  | ICD-9 Code(s)         | Patient's Current Weight      |

| 2. PHYSICIAN INFORMATION     |                            |                             |                     |
|------------------------------|----------------------------|-----------------------------|---------------------|
| Physician Last Name          | Physician First Name       | Physician DEA or NPI Number | Physician Tax ID    |
| Address                      | City                       | State                       | Zip Code            |
| Office Phone Number<br>( ) - | Office Fax Number<br>( ) - | Office Contact Name         | Physician Specialty |

| 3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.   |  |                          |                   |
|--|--|--------------------------|-------------------|
| Drug Name (please specify brand name)  | HCPCS or CPT Code(s)<br><input type="checkbox"/> J2940 <input type="checkbox"/> J2941 <input type="checkbox"/> Q0515 |                          | Strength / Dose   |
| Direction for Use (SIG)  |  |                          |                   |
| Date patient is scheduled to be treated (need by date)<br>/ /  | Service From Date<br>/ /   | Service Thru Date<br>/ / | Number of Refills |
| Place of Service<br><input type="checkbox"/> MD Office <input type="checkbox"/> Pt's Home <input type="checkbox"/> Other: (please specify) |  |                          |                   |
| Prescriber Signature   |  |                          | Date<br>/ /       |

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**4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide **ALL** supporting lab results, progress notes, etc.

**(1) Growth Hormone Deficiency in Children (initial therapy)**

- Yes  No Does pt have a subnormal response (< 10 ng/mL) to any one of the following GH stimulation tests?
- |                                    |   |                                      |
|------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Arginine  | <input type="checkbox"/> Glucagons                    | <input type="checkbox"/> L-dopa      |
| <input type="checkbox"/> Clonidine | <input type="checkbox"/> Insulin induced hypoglycemia | <input type="checkbox"/> Propranolol |
- Yes  No Does pt have at least three (3) other pituitary hormone deficiencies?
- Yes  No Is pt a neonate with hypoglycemia and clinical & hormone evidence of hypopituitarism?

**(2) Growth Hormone Deficiency in Children (continuation therapy)**

- Yes  No Does the pt's annual medical review demonstrate a doubling of pre-treatment growth rate or an increase in pre-treatment growth rate of 3 cm/year or more seen in the first year of therapy?
- Yes  No For continued therapy past the first year, did the pt's growth rate remain above 2.5 cm/year?
- Yes  No For pt > 12 y.o., did an x-ray report show that epiphyses have not yet closed?

**(3) Growth Hormone Reconstructive Therapy in Children & Adolescents**

- Yes  No Is pt's estimated adult height, based on bone age  $\geq 2.5$  standard deviations below the mean for conditions known to be responsive to GH therapy?
- Yes  No Is pt diagnosed with chronic renal insufficiency?
- Yes  No Is pt diagnosed with idiopathic short stature?
- Yes  No Is pt diagnosed with Prader-Willi syndrome?
- Yes  No Is pt diagnosed with Noonan syndrome?
- Yes  No Is pt diagnosed with Turner syndrome?
- Yes  No Was pt born small for gestational age defined by (check all that applies)?
- Birth weight or length was  $\geq 2$  standard deviations below the mean for gestational age
  - Pt failed to manifest catch up growth by age 2; height is  $\geq 2$  standard deviations below the mean for age and sex
  - Pt presents with other causes for short stature, e.g. growth inhibiting medication, chronic disease, endocrine disorders, emotional deprivation or syndromes have been ruled out
- Yes  No Is pt diagnosed with other short stature not associated with GH deficiency, e.g. partial GH deficiency. neuronsecretory dysfunction?

**(4) Growth Hormone Therapy in Adolescents and Young Adults**

- Yes  No Does pt have documented GH deficiency in childhood with a growth rate of less than 2 cm per year?
- Yes  No Has GH treatment been stopped for at least 3 months and the diagnosis of GH deficiency has been reconfirmed?
- Yes  No Did pt have a subnormal response (< 10 ng/mL serum GH concentration) to 2 standard GH stimulation tests?
- Yes  No Did pt have a subnormal response (< 10 ng/mL serum GH concentration) to 1 provocative test and low IGF-I / IGFBP-3?
- Yes  No Does pt have at least 3 other documented pituitary hormone deficiencies?

**(5) Growth Hormone Therapy in Adults**

- Yes  No Does pt have documented GH deficiency in childhood?
- Yes  No Did pt have a subnormal response to 2 standard growth hormone stimulation tests defined as (check all that applies):
- Serum GH concentration  $\leq 5$  ng/mL when using insulin induced hypoglycemia testing
  - Serum GH concentration  $\leq 4$  ng/mL when using arginine
- Yes  No Did pt have a subnormal response to 1 stimulation test with documented hypothalamic or pituitary disease and one or more additional pituitary hormone deficiencies?
- Yes  No Does pt have at least 3 other documented pituitary hormone deficiencies?

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**APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY (continue)**

**(6) AIDS Wasting Syndrome**

Yes  No Does pt have AIDS wasting syndrome, defined as > 10% of baseline weight loss that is unexplained by another concurrent illness, other than HIV infection?

Yes  No Is pt receiving anti-retroviral therapy?

**(7) Short Bowel Syndrome**

Yes  No Does pt have short bowel syndrome and is receiving specialized nutritional support?

**(8) Other Use(s)** (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

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**5. PHYSICIAN SIGNATURE**

|  |     |
|--|-----|
|  | / / |
|--|-----|

**Prescriber Signature**

**Date**

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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**Medical Policy Reference can be found at: [www.bcbsga.com](http://www.bcbsga.com)**

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