

Anthem UM Services, Inc.

**REVIEW REQUEST FOR
Growth Hormone**

Provider Data Collection Tool Based on Medical Policy DRUG.00009

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

Policy Last Review Date: 05/19/2011	Policy Effective Date: 07/13/2011	Provider Tool Effective Date: 07/13/2011
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Request Date: / /		<input type="checkbox"/> Initial Request		<input type="checkbox"/> Subsequent Request	
<input type="checkbox"/> Buy and Bill					
Individual's Name:			Date of Birth: / /		
Insurance Identification Number:			Individual's Phone Number:		
Primary Diagnosis:		ICD-9 Code(s) (if known):		Individual's Weight _____ <input type="checkbox"/> (lbs) <input type="checkbox"/> (kg)	
Ordering Provider Name & Specialty:				Provider ID Number (if known):	
Office Address:					
Contact Name and Office Phone Number:				Office Fax Number:	
Servicing Provider Name & Specialty (If different than Ordering Provider):				Provider ID Number (if known):	
Office Address:					
Contact Name and Office Phone Number:				Office Fax Number:	
Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Office <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Outpatient Hospital <input type="checkbox"/> Ambulatory Infusion <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Other: _____					
Drug Name/HCPs Code (if known)			Dose to be administered: _____ (mg/kg)		
Genotropin® <input type="checkbox"/> J2941 Humatrope® <input type="checkbox"/> J2941 Norditropin® <input type="checkbox"/> J2941 Nutropin® <input type="checkbox"/> J2941 Saizen® <input type="checkbox"/> J2941 Serostim® <input type="checkbox"/> J2941 Somatropin <input type="checkbox"/> J2941 Nutropin AQ® <input type="checkbox"/> J2941 Tev-Tropin® <input type="checkbox"/> J2941 Omnitrope® <input type="checkbox"/> J2941 Zorbtive® <input type="checkbox"/> J2941 Somatrem <input type="checkbox"/> J2940 Geref® <input type="checkbox"/> Q0515 Other: _____			_____ (Other)		
When did the individual first start this drug? / /			Frequency (Days, Wks, Months) _____		
Duration: _____ (Weeks)			Start Date For This Request: / /		

Please check all that apply to the individual:

(1) Growth Hormone Deficiency in Children and adolescents

Initial Authorization Only

- Individual is under 18 years of age (Please check any of the following that apply)
 - Individual has a subnormal response (less than 10 ng/ml) to any **TWO** of following standard Growth Hormone (GH) Stimulation tests

<input type="checkbox"/> Arginine	<input type="checkbox"/> Insulin induced hypoglycemia
<input type="checkbox"/> Clonidine	<input type="checkbox"/> L-dopa - Propranolol
<input type="checkbox"/> Glucagons	<input type="checkbox"/> Other
 - Individual has at least 2 pituitary hormone deficiencies. For example, individual is on medications for at least 2 other pituitary hormone deficiencies such as thyroid replacement (e.g. Synthroid®) and steroid replacement (e.g. prednisone or cortisone)
 - Individual's IGF-1 measurement is below age-appropriate level
 - Individual is neonate with hypoglycemia and clinical and hormone evidence of hypopituitarism

Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan. 1

- Other hormone deficiencies
Please List deficiencies: _____

For Re-Authorization Only

- Individual is **under** 18 years of age. (Please check the following that apply):
- Individual is currently in 1st year of treatment
 - Individual has demonstrated a doubling of pre-treatment growth rate
 - Individual has an increase in pretreatment growth rate of 3cm/year or more
 - Individual is 12 years of age or younger
 - Individual is **over** 12 years of age and one of the following:
 - There is an x-ray report with evidence that epiphyses have not yet closed
 - Prior documented hypopituitarism
 - The Sexual Maturity Rating (SMR, Tanner Stage) is less than or equal to 3
 - Other _____
 - Individual is currently past the 1st year of treatment.
 - Individual's growth rate is above 2.5 cm/year
 - Individual is 12 years of age or younger
 - Individual is **over** 12 years of age
 - There is an x-ray report with evidence that epiphyses have not yet fused
 - Prior documented hypopituitarism
 - The Sexual Maturity Rating (SMR, Tanner Stage) is less than or equal to 3
 - Other _____

(2) Reconstructive Therapy Initial Request and Reauthorization

- Individual is under 18 years of age (Please check any of the following that apply):
- Individual's mean height is at least 2.25 but less than 2.5 standard deviations below the mean for age and gender
- Individual's growth velocity is less than 10th percentile over 1 year
- Individual's mean height is at least 2.5 standard deviations below the mean for age and gender, regardless of growth velocity
- Individual's condition is known to be responsive to GH therapy (Please check any of the following that apply):
- Chronic renal insufficiency
 - Idiopathic short stature
 - Prader-Willi Syndrome
 - (with BMI less than 35)
 - Noonan Syndrome
 - Turner Syndrome
 - Individual has Short Stature Homeobox (SHOX) gene
 - Individual was born small for gestational age defined (Please check all of the following that apply):
 - Birth weight or length was 2 or more standard deviations below the mean for gestational age
 - Individual has failed to manifest catch up growth **before** 4 years of age (height is 2 or more standard deviations below the mean for age and sex)
 - Other causes for short stature have been ruled out
 - Other _____

Please check any of the following that apply:

- Bone age is less than 16 years (male), or at least 14 years (female)
- Epiphyseal fusion has not occurred
- Mid-parental height has not been achieved. [(father's height + mother's height) divided by 2, plus 2.5 inches (male) or minus 2.5 inches (female)].

(3) Hormone Therapy in Adolescents and Young Adults

- Individual is 21 years of age or younger
- Individual had a documented GH deficiency in childhood with a growth rate of less than 2cm per year
- Individual has idiopathic isolated GHD (Growth Hormone Deficiency)
 - Growth hormone treatment stopped for at least 1 month and the diagnosis of GHD has been reconfirmed
 - Individual with a subnormal response (GH concentration of less than 10 ng/ml) to any 1 of following provocative tests

<input type="checkbox"/> Arginine	<input type="checkbox"/> Insulin induced hypoglycemia
<input type="checkbox"/> Clonidine	<input type="checkbox"/> L-dopa
<input type="checkbox"/> Glucagons	<input type="checkbox"/> Propranolol
 - Individual has a low IGF-I/IGFBP-3
 - There is a subnormal response (GH concentration of less than 10 ng/ml) to 2 standard GH stimulation tests:

<input type="checkbox"/> Arginine	<input type="checkbox"/> Insulin induced hypoglycemia
<input type="checkbox"/> Clonidine	<input type="checkbox"/> L-dopa
<input type="checkbox"/> Glucagons	<input type="checkbox"/> Propranolol
 - Individual has multiple pituitary hormone deficiencies (with or without tumor/radiation)
 - Growth hormone treatment stopped for at least 1 month and the diagnosis of GHD has been reconfirmed
 - There is a subnormal response (GH concentration of less than 10 ng/ml) to 1 provocative test

<input type="checkbox"/> Arginine	<input type="checkbox"/> Insulin induced hypoglycemia
<input type="checkbox"/> Clonidine	<input type="checkbox"/> L-dopa
<input type="checkbox"/> Glucagons	<input type="checkbox"/> Propranolol
 - Individual has low IGF-I/IGFBP-3

- Individual has a known genetic mutation associated with deficient growth hormone production or secretion
- Individual has a Hypothalamic-pituitary tumor or structural defect
- Individual has presence of at least 3 other pituitary hormone deficiencies. For example, individual is on medications for at least 3 other pituitary hormone deficiencies such as thyroid replacement (e.g. Synthroid[®]), steroid replacement (e.g. prednisone or cortisone), and hormone replacement (e.g. estrogen or testosterone)
- Other hormone deficiencies

Please List deficiencies: _____

(4) Growth Hormone Deficiency in Adults

- Individual is over 18 years of age. (Please check the following that apply):

Individual has one of the following conditions:

- Documented GHD in childhood
- Documented hypopituitarism as result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma

- Individual had a subnormal response in adults to 2 standard growth hormone stimulation tests:

- The Arginine serum GH concentration is less than or equal to 4.1ng/ml
- There is insulin induced hypoglycemia. (Serum GH concentration is less than or equal to 5ng/ml)
- Other _____

- Individual had a subnormal response to 1 standard GH stimulation test

- Individual has one or more additional pituitary hormone deficits

- Individual has at least 3 other pituitary hormone deficiencies. For example, individual is on medications for at least 3 other pituitary hormone deficiencies such as thyroid replacement (e.g. Synthroid[®]), steroid replacement (e.g. prednisone or cortisone), and hormone replacement (e.g. estrogen or testosterone)

- Other hormone deficiencies

Please List deficiencies: _____

(5) Short Bowel Syndrome

- Individual is receiving specialized nutritional support

- Other _____

(6) AIDS Wasting Syndrome

- Individual has had more than 10% baseline weight loss that cannot be explained by concurrent illness other than HIV infection

- Individual will simultaneously be treated with antiviral therapy

- Other _____

(7) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim

- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name & Title of Provider or Provider Representative Completing Form
& attestation (Please Print)*

/ /
Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

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