Prior Authorization Form
Growth Hormone

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: __ – __ – ____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: ___ – ___ – ____

Office Fax Number: ___ – ___ – ____

CLINICAL CRITERIA

You must provide pertinent clinical documentation (recent clinical notes, growth charts, lab results, and growth hormone stimulations test report).

1. What medication is being requested? ____
2. The preferred agent is Norditropin®; is there a clinical reason the member cannot use the preferred agent?

   ☐ Yes ☐ No

   If **Yes**, list reason(s):

   ____

(Form continued on next page.)

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Member's Last Name: ______________ **Member's First Name:** ______________

3. What is the diagnosis for the medication?
   - ☐ Growth hormone deficiency (GHD) – pediatric
   - ☐ Small for gestational age (SGA) – pediatric
   - ☐ Prader-Willi syndrome – pediatric
   - ☐ Noonan syndrome – pediatric
   - ☐ Childhood onset growth hormone deficiency – adult
   - ☐ Turner syndrome – pediatric
   - ☐ Chronic renal insufficiency with associated growth retardation – pediatric
   - ☐ Panhypopituitarism, iatrogenic pituitary disorder, pituitary tumor, idiopathic short stature – pediatric
   - ☐ Adult onset evidence of hypothalamic-pituitary disease or history of cranial irradiation – adult
   - ☐ Other: ____

For Pediatric Members:

1. Have other causes of growth hormone deficiency been ruled out?
   ☐ Yes ☐ No
2. Does the member have open bony epiphyses?
   ☐ Yes ☐ No
3. What is the member's bone age and the date of the study?
   ____
4. Is the bone age less than the member's chronological age?
   ☐ Yes ☐ No
5. What are the member's current height and weight?
   ____
6. Is the member's height less than the 5th percentile for chronological age?
   ☐ Yes ☐ No
7. Is the member's weight or length more than 2 standard deviations (SD) below the mean for gestational age?
   ☐ Yes ☐ No
8. Has the member failed to reach catch-up growth by age 4?
   ☐ Yes ☐ No
9. Is the member's growth velocity less than the 10th percentile? Please provide growth chart.
   ☐ Yes ☐ No
10. Does the member have severe growth retardation with height more than 3 SD below the mean for chronological age and sex?
    ☐ Yes ☐ No

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

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

11. Does the member have moderate growth retardation with height between 2 and 3 SD below the mean for chronological age and sex and decreased growth rate?
    ☐ Yes ☐ No
12. Is the member prepubertal?
    ☐ Yes ☐ No
13. Has the member's growth velocity been measured over 1 year prior to therapy initiation and was it found to be 2 or more SD below the mean for age and sex?
    ☐ Yes ☐ No
14. Does the member have **two** documented failed stimulation tests (peak serum growth hormone value of less than 10 mcg/L after GH stimulation) as determined by standardized lab testing?
    ☐ Yes ☐ No
15. Does the member have a hypothalamic-pituitary defect (i.e., congenital malformation, tumor, or irradiation) and a deficiency in at least one additional pituitary hormone?
    ☐ Yes ☐ No

For **Turner Syndrome**:

16. Has the diagnosis been confirmed by chromosome analysis?
    ☐ Yes ☐ No

For **GHD Associated with Chronic Renal Insufficiency**:

17. Does the member have chronic renal insufficiency?
    ☐ Yes ☐ No

For **Short Stature Homeobox Gene (SHOX) Deficiency**:

18. Has the diagnosis been confirmed by gene analysis?
    ☐ Yes ☐ No

For Pediatric Members Renewal:

1. Does the member have open bony epiphyses?
   ☐ Yes ☐ No
2. Is the height velocity 2 cm/year over the previous untreated rate? Provide documentation.
   ☐ Yes ☐ No
3. Has the child reached the 25th percentile of normal adult height? Provide documentation.
   ☐ Yes ☐ No
4. Is serum insulin-like growth factor (IGF-1) being monitored and the dose of growth hormone being reduced if IGF-1 exceeds the normal range of the referencing laboratory for age or pubertal stage?
   ☐ Yes ☐ No
5. Does the member have toxicity (i.e., intracranial hypertension, scoliosis progression, slipped capital femoral epiphysis [SCFE], neoplasia, etc.) from the medication?
   ☐ Yes ☐ No

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

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

For Adult Members:

1. Has the member been evaluated for other endocrine disorders?
   ☐ Yes ☐ No
2. Is the member receiving adequate replacement therapy for any other pituitary hormone deficiencies?
   ☐ Yes ☐ No

For Documented **Childhood Onset GH Deficiency**:

3. Has the member failed the stimulation test?
   ☐ Yes ☐ No

For Adult Members Renewal:

1. Is serum insulin-like growth factor (IGF-1) being monitored and the dose of growth hormone being reduced if IGF-1 exceeds the normal range of the referencing laboratory?
   ☐ Yes ☐ No
2. Does the member have toxicity (e.g., intracranial hypertension, scoliosis progression, slipped capital femoral epiphysis [SCFE], neoplasia) from the medication?
   ☐ Yes ☐ No
3. Has the member shown beneficial response to treatment evidenced by improvement in quality of life based on Quality of Life In Adult Growth Hormone Deficiency Assessment (QoL-AGHDA) or objective improvements in biochemistry, body composition, or bone mineral density?
   ☐ Yes ☐ No

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

____ ____________________

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

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