

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Human Growth Hormone (HGH)**

Complete form in its entirety and fax to:

**Prior Authorization of Benefits (PAB) Center at (866) 807- 6241**
**1. PATIENT INFORMATION**
**2. PHYSICIAN INFORMATION**

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

**3. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**
**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

<b>Preferred HGH:</b> <input type="checkbox"/> Humatrope <input type="checkbox"/> Nutropin <input type="checkbox"/> Nutropin AQ	<b>Non-Preferred HGH:</b> <input type="checkbox"/> Accretropin <input type="checkbox"/> Genotropin <input type="checkbox"/> Norditropin <input type="checkbox"/> Omnitrope <input type="checkbox"/> Saizen <input type="checkbox"/> Serostim <input type="checkbox"/> Tev-Tropin <input type="checkbox"/> Valtropin <input type="checkbox"/> Zorbtive	<b>Non-Preferred HGH agents require a trial of Humatrope AND Nutropin AND/OR Nutropin AQ unless non-formulary agent has FDA approved indication that is not approved for the formulary agent(s). Check applicable boxes:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is a new user of requested medication <input type="checkbox"/> Yes <input type="checkbox"/> No Patient has tried a preferred HGH within the previous 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No Patient is currently established on requested medication
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**DIAGNOSIS:**

<input type="checkbox"/> Growth Hormone Deficiency <input type="checkbox"/> Growth Failure Secondary to Chronic Renal Insufficiency <input type="checkbox"/> Child Born Small for Gestational Age <input type="checkbox"/> Prader-Willi <input type="checkbox"/> Turner's Syndrome	<input type="checkbox"/> AIDS related cachexia <input type="checkbox"/> Idiopathic Short Stature <input type="checkbox"/> Short Bowel Syndrome <input type="checkbox"/> Noonan Syndrome Other _____
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**For growth failure associated with GHD, Chronic Renal Insufficiency, and End Stage Renal Disease:**

<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient undergone pituitary surgery or radiation therapy?			
Please indicate what Growth Hormone Stimulation Tests have been performed:	<input type="checkbox"/> Insulin Induced Hypoglycemia <input type="checkbox"/> Clonidine	<input type="checkbox"/> Arginine <input type="checkbox"/> L-dopa	<input type="checkbox"/> Glucagons <input type="checkbox"/> Propranolol
Date:	List <b>and attach</b> copy of Growth Hormone Stimulation Test Results <b>and</b> Reagents Used		
Reagents:			
Patient's Height (include date):	Results:	Results:	
Patient's Bone Age (include date):	Results:	Results:	

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Patient Name: \_\_\_\_\_ Patient ID #: \_\_\_\_\_

Patient's Chronological Age:	Results:	Results:
Growth Velocity:	Results:	Results:
IGF-1 Results:	Results:	Results:

 How many standard deviations (SD) below the mean is this patient for final adult skeletal age (delayed bone age)? \_\_\_\_\_  
 What growth velocity percentile (measured at least over 1 year) does this patient fall under? \_\_\_\_\_  
 How many standard deviations (SD) below the mean is this patient for final adult height? \_\_\_\_\_  
 What growth percentile for age does this patient fall under if the above question is unknown? \_\_\_\_\_

**For growth failure due to Prader-Willi Syndrome:**

 Does the patient have any of the following risk factors?
  Severe Obesity
  History of Respiratory Impairment
  Unidentified Respiratory Infection  
 Sleep Apnea
  Other \_\_\_\_\_

**For children born Small for Gestational Age (SGA):**

 How many standard deviations (SD) below the mean is this patient for their age for the following parameters:  
 Length / Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
**Are there any other factors that may contribute to the shortness of stature such as growth inhibiting medications, chronic diseases, endocrine disorders, emotional deprivation or syndromes?**  
 If yes, to the above, please list: \_\_\_\_\_ \*\* Provide growth curves

**For AIDS Wasting Syndrome:**

What baseline percentage weight loss has this patient experienced? \_\_\_\_\_

**Review for medical necessity for children should occur annually:**
**Result of the first year of therapy:**  
 Yes  No Has there been a doubling of the pre-treatment growth rate?  
 Yes  No Has there been an increase in pre-treatment growth rate of 3cm per year or more?  
**For therapy continuing past the first year:**  
 Yes  No Has the growth rate remained above 2.5cm per year?  
**For children over 12 years of age:**  
 Yes  No Has there been an x-ray report that shows that the epiphyses has not yet closed?  
 Yes  No Is the Sexual Maturity Rating (SMR, Tanner Stage) less than or equal to 3?

**4. PHYSICIAN SIGNATURE**

 \_\_\_\_\_  
 Prescriber or Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Prior Authorization of Benefits 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. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.  
 Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

**IMPORTANT WARNING:** This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this information is **STRICTLY PROHIBITED**. If you have received this message by error, please notify us immediately at **(800) 338-6180** and destroy the related message or return the document to us at 8407 Fallbrook Avenue AF13, West Hills, CA 91304. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without appropriate patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in Federal and State law.