1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Genotropin® Prior Authorization Request Form (Page 1 of 5)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Pediatric growth hormone deficiency
❑ Growth hormone deficiency in adults
❑ Growth hormone deficiency in transition phase adolescents
❑ Idiopathic short stature (ISS)
❑ Isolated growth hormone deficiency in adults
❑ Pediatric growth failure associated with chronic renal insufficiency
❑ Prader-W illi syndrome
❑ Short-stature homeobox (SHOX) gene deficiency
❑ Small for gestational age (SGA)
❑ Turner syndrome or Noonan syndrome
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Is Genotropin prescribed by or in consultation with an endocrinologist? ❑ **Yes** ❑ **No**
For patients with chronic renal insufficiency, is Genotropin prescribed by or in consultation with a nephrologist? ❑ **Yes** ❑ **No**
Select if the patient has had a trial and failure or intolerance to the following:
❑ Norditropin
❑ Nutropin AQ/Nutropin AQ Nuspin
❑ Omnitrope

For pediatric growth hormone deficiency, also answer the following:

Is the patient an infant < 4 months of age? ❑ **Yes** ❑ **No**
Does the infant have growth deficiency? ❑ **Yes** ❑ **No**
Does the patient have history of neonatal hypoglycemia associated with pituitary disease? ❑ **Yes** ❑ **No**
Does the patient have panhypopituitarism? ❑ **Yes** ❑ **No**
Is the patient's height > 2.0 standard deviations [SD] below mid-parental height? ❑ **Yes** ❑ **No**
Is the patient's height > 2.25 SD below population mean (below the 1.2 percentile for age and gender)? ❑ **Yes** ❑ **No**
Is the patient's growth velocity > 2 SD below mean for age and gender? ❑ **Yes** ❑ **No**
Does the patient have delayed skeletal maturation of > 2 SD below mean for age and gender (e.g., delayed > 2 years compared with chronological age)? ❑ **Yes** ❑ **No**

<Continued on next page>

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Genotropin® Prior Authorization Request Form (Page 2 of 5)

<Continuation of pediatric growth hormone deficiency>

Is the patient's bone age < 16 years for males or < 14 years for females? ❑ **Yes** ❑ **No**

Select if the patient has undergone provocative GH stimulation tests with the following: ***(Document the GH response)***

- ❑ Arginine Peak value:_____mcg/L
- ❑ Clonidine Peak value:_____mcg/L
- ❑ Glucagon Peak value:_____mcg/L
- ❑ Insulin Peak value:_____mcg/L
- ❑ Levodopa Peak value:_____mcg/L
- ❑ Growth hormone releasing hormone Peak value:_____mcg/L

For patients than 1 year of age, select if the following is below the age and gender adjusted normal range as provided by the physician's lab: ***(Document the specified lab value and reference range)***

- ❑ Insulin-like growth factor 1 (IGF-1/Somatomedin-C) IGF-1/Somatomedin-C level:_____Reference range: _____
- ❑ Insulin growth factor binding protein-3 (IGFBP-3) IGFBP-3 level:_____Reference range: _____

Will pediatric growth hormone dosing be utilized as defined by the prescribing information? ❑ **Yes** ❑ **No**

Reauthorization:

Please document that the patient has had a height increase of at least 2 cm/year over the previous year of treatment below:

Previous height:_____ Date obtained: _____

Current height:_____Date obtained: _____

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Document the expected adult height goal: _____

For growth hormone (GH) deficiency in adults, also answer the following:

Are there clinical records supporting a diagnosis of childhood-onset GH deficiency? ❑ **Yes** ❑ **No**

Does the patient have adult-onset GH deficiency? ❑ **Yes** ❑ **No**

Are there clinical records documenting that hormone deficiency is a result of hypothalamic -pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)? ❑ **Yes** ❑ **No**

Select if the patient has undergone one of the following GH stimulation tests to confirm adult GH deficiency and the peak GH value is as follows:

- ❑ Insulin tolerance test (ITT) ≤ **5 mcg/L**
- ❑ Arginine & GH-releasing hormone (GHRH+ARG) ≤ **11 mcg/L** if body mass index (BMI) is < 25 kg/m^2 ; ≤ **8 mcg/L** if BMI is ≥ 25 and < 30 kg/m^2; ≤ **4 mcg/L** if BMI is ≥ 30 kg/m^2
- ❑ Glucagon ≤ **3 mcg/L**
- ❑ Arginine (ARG) ≤ **0.4 mcg/L**

Select if there is documentation the patient has deficiency of the following anterior pituitary hormones:

- ❑ Adrenocorticotropic hormone (ACTH)
- ❑ Follicle-stimulating hormone/luteinizing hormone (FSH/LH)
- ❑ Prolactin
- ❑ Thyroid stimulating hormone (TSH)

Does the patient have an IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab? ❑ **Yes** ❑ **No**

Does the patient have panhypopituitarism? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with aromatase inhibitors (e.g., Arimidex [anastrozole], Femara [letrozole])? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with androgens (e.g., Delatestryl [testosterone enanthate], Depo-Testosterone [testosterone cypionate])? ❑ **Yes** ❑ **No**

Will adult GH dosing be utilized as defined by the prescribing information? ❑ **Yes** ❑ **No**

Reauthorization:

Is there evidence of ongoing monitoring as demonstrated by documentation within the pas t 12 months of an IGF-1/Somatomedin-C level? ❑ **Yes** ❑ **No**

Does the patient have panhypopituitarism? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with aromatase inhibitors (e.g., Arimidex [anastrozole], Femara [letrozole])? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with androgens (e.g., Delatestryl [testosterone enanthate], Depo -Testosterone [testosterone cypionate])? ❑ **Yes** ❑ **No**

Will adult GH dosing be utilized as defined by the prescribing information? ❑ **Yes** ❑ **No**

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Genotropin® Prior Authorization Request Form (Page 3 of 5)

For growth hormone (GH) deficiency in transition phase adolescents, also answer the following:

Will adult GH dosing be utilized as defined by the prescribing information (additional information may be found in the AACE 2 009 treatment guideline)? ❑ **Yes** ❑ **No**

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Are the patient's epiphyses closed on bone radiograph? ❑ **Yes** ❑ **No**

Select if there is documentation the patient has high risk of GH deficiency due to GH deficiency in childhood from one of the following:

- ❑ Embryopathic/congenital defects
- ❑ Genetic mutations
- ❑ Irreversible structural hypothalamic-pituitary disease
- ❑ Panhypopituitarism
- ❑ Deficiency of three or more of the following anterior pituitary hormones: ACTH, TSH, Prolactin, FSH/LH

Does the patient have an IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab? ❑ **Yes** ❑ **No**

Is the patient at low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic deficiency)? ❑ **Yes** ❑ **No**

Has GH therapy been discontinued for at least 1 month? ❑ **Yes** ❑ **No**

Select if the patient has undergone one of the following GH stimulation tests after discontinuation of therapy for at least 1 month and the peak GH value is as follows:

- ❑ Insulin tolerance test (ITT) ≤ **5 mcg/L**
- ❑ Arginine & GH-releasing hormone (GHRH+ARG) ≤ **11 mcg/L** if body mass index (BMI) is < 25 kg/m^2 ; ≤ **8 mcg/L** if BMI is ≥ 25 and < 30 kg/m^2; ≤ **4 mcg/L** if BMI is ≥ 30 kg/m^2
- ❑ Glucagon ≤ **3 mcg/L**
- ❑ Arginine (ARG) ≤ **0.4 mcg/L**

Reauthorization:

Is there evidence the patient has had a positive response to therapy (e.g., increase in total lean body mass, exercise capaci ty or IGF-1 and IGFBP-3 levels)? ❑ **Yes** ❑ **No**

Will adult GH dosing be utilized as defined by the prescribing information (additional information may be found in the AACE 2009 treatment guideline)? ❑ **Yes** ❑ **No**

For isolated growth hormone deficiency in adults, also answer the following:

Is there documentation the patient has deficiency of GH defined by a failure to produce a peak serum GH level of > 5 mcg/L after provocative pharmacologic stimulation by two of the following tests: Insulin, L-arginine, and/or glucagon? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with aromatase inhibitors (e.g., Arimidex [anastrozole], Femara [letrozole])? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with androgens (e.g., Delatestryl [testosterone enanthate], Depo-Testosterone [testosterone cypionate])? ❑ **Yes** ❑ **No**

Reauthorization:

Is there evidence of ongoing monitoring as demonstrated by documentation within the past 12 months of an IGF-1/Somatomedin-C level? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with aromatase inhibitors (e.g., Arimidex [anastrozole], Femara [letrozole])? ❑ **Yes** ❑ **No**

Will the requested medication be used in combination with androgens (e.g., Delatestryl [testosterone enanthate], Depo-Testosterone [testosterone cypionate])? ❑ **Yes** ❑ **No**

For pediatric growth failure associated with chronic renal insufficiency, also answer the following:

Is the patient's bone age < 16 years for males or < 14 years for females? ❑ **Yes** ❑ **No**

Reauthorization:

Please document that the patient has had a height increase of at least 2 cm/year over the previous year of treatment below:

Previous height:_____ Date obtained: _____

Current height:_____Date obtained: _____

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Document the expected adult height goal: _____

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Genotropin® Prior Authorization Request Form (Page 4 of 5)

For Prader-Willi syndrome, also answer the following:

Reauthorization:

Is there evidence the patient has had a positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)? ❑ **Yes** ❑ **No**

Please document that the patient has had a height increase of at least 2 cm/year over the previous year of treatment below:

Previous height:_____ Date obtained: _____

Current height:_____Date obtained: _____

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Document the expected adult height goal: _____

For short-stature homeobox (SHOX) gene deficiency, also answer the following:

Does the patient have a diagnosis of pediatric growth failure with short stature homeobox (SHOX) gene deficiency as confirmed by genetic testing? ❑ **Yes** ❑ **No**

Is the patient's bone age < 16 years for males or < 14 years for females? ❑ **Yes** ❑ **No**

Reauthorization:

Please document that the patient has had a height increase of at least 2 cm/year over the previous year of treatment below:

Previous height:_____ Date obtained: _____

Current height:_____Date obtained: _____

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Document the expected adult height goal: _____

For small for gestational age (SGA), also answer the following:

Select if the diagnosis of SGA is based on demonstration of catch up growth failure in the first 24 months of life using a 0-36 month growth chart as confirmed by one of the following:

❑ Patient's **birth weight** was below the 3rd percentile for gestational age (> 2 SD below population mean)

❑ Patient's **birth length** was below the 3rd percentile for gestational age (> 2 SD below population mean)

Does patient's height remain ≤ the 3rd percentile (> 2 SD below population mean)? ❑ **Yes** ❑ **No**

Reauthorization:

Please document that the patient has had a height increase of at least 2 cm/year over the previous year of treatment below:

Previous height:_____ Date obtained: _____

Current height:_____Date obtained: _____

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Document the expected adult height goal: _____

For Turner syndrome (gonadal dysgenesis) or Noonan syndrome, also answer the following:

Is the patient's bone age < 16 years for males or < 14 years for females? ❑ **Yes** ❑ **No**

Is the patient's height below the 5th percentile on growth charts for age and gender? ❑ **Yes** ❑ **No**

Reauthorization:

Please document that the patient has had a height increase of at least 2 cm/year over the previous year of treatment below:

Previous height:_____ Date obtained: _____

Current height:_____Date obtained: _____

Has the expected adult height been reached? ❑ **Yes** ❑ **No**

Document the expected adult height goal: _____

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Genotropin® Prior Authorization Request Form (Page 5 of 5)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician fe els is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	