

### Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to [www.uhccommunityplan.com](http://www.uhccommunityplan.com) for medication fax request forms.)

#### Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

#### Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

#### Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature\*\*: DAW (Initial here):

**Physician Signature\*\*:** By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

#### Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐ Yes ☐ No

Is this medication a **New Start**? ☐ Yes ☐ No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

**\*\*Please attach any pertinent clinical information that would pertain to support stated diagnosis.**

**Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

#### Delivery Instructions

**Note:** Delivery coordination requires a "Physician Signature" above and complete "Provider Information" and "Patient Information"

**Note:** All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

**Ship to:** Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self Administered ☐ LTC ☐ Physician's Office ☐

## Human Growth Hormone, Growth Stimulating Products - Arizona PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form contains multiple pages. Please complete all pages to avoid a delay in our decision.**

**Allow at least 24 hours for review.**

### Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

**Is the requested medication** ☐ **New or** ☐ **Continuation of Therapy?** If continuation, list start date: \_\_\_\_\_

**Is this patient currently hospitalized?** ☐ **Yes** ☐ **No** If recently discharged, list discharge date: \_\_\_\_\_

### Section B - Physician Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

### Section C - Medical Information

Medication:	Strength:
Directions for use:	Quality:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

**Is this member pregnant?** ☐ **Yes** ☐ **No** If yes, what is this member's due date? \_\_\_\_\_

### Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

### Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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## Clinical and Drug Specific Information

**All Requests including Growth Failure Associated with Chronic Insufficiency AND Prader-Willi**

**- What is the indication for this medication? (check all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Pediatric growth hormone deficiency   | <input type="checkbox"/> Prader-Willi syndrome  |
| <input type="checkbox"/> Growth failure in children small for gestational age (SGA)                  | <input type="checkbox"/> Turner syndrome (gonadal dysgenesis)                                 |
| <input type="checkbox"/> Noonan syndrome   | <input type="checkbox"/> Adult growth hormone deficiency                                      |
| <input type="checkbox"/> Transition phase adolescent patient   | <input type="checkbox"/> Short bowel syndrome   |
| <input type="checkbox"/> Severe primary IGF-1 deficiency   | <input type="checkbox"/> Growth hormone gene deletion   |
| <input type="checkbox"/> Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency | <input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia  | <input type="checkbox"/> Other, List: _____   |

**- If applicable, is the patient Tanner Stage 3 or greater?** ☐ Yes ☐ No

**- Has the patient been evaluated by one of the following:** ☐ Endocrinologist ☐ Nephrologist ☐ N/A

**- Does the request include a current growth chart and results of all required diagnostic testing?** ☐ Yes ☐ No  
(please attach documentation)

**- What is the patient's bone age?** \_\_\_\_\_ **Date of Bone Age Study:** \_\_\_\_\_

**- Does the patient have open epiphyses?** ☐ Yes ☐ No

**- If the requested medication is non-preferred, is there a reason or special circumstance that the patient must be treated with a non-preferred medication?** ☐ Yes ☐ No  
If yes, explain: \_\_\_\_\_

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests) \*\***

### Requests for Pediatric Growth Hormone Deficiency

**- Is the infant <4 months of age with growth deficiency?** ☐ Yes ☐ No

**- Is there a diagnosis of panhypopituitarism?** ☐ Yes ☐ No

**- Is there a history of neonatal hypoglycemia associated with pituitary disease?** ☐ Yes ☐ No

**- Is the patient's projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to the 18-20 year mark) >2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height?** ☐ Yes ☐ No

**- Is the patient's height >2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height?** ☐ Yes ☐ No

**- Does the patient have 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

**- Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has undergone any of the following provocative growth hormone (GH) stimulation tests:** ☐ Yes ☐ No  
(check all that apply)

- ☐ Arginine ☐ Clonidine ☐ Glucagon ☐ Insulin ☐ Levodopa ☐ Growth hormone releasing hormone

**- List two Growth Hormone response values:** \_\_\_\_\_ mcg/L \_\_\_\_\_ mcg/L

**- Is one of the following below the age and gender adjusted normal range as provided by the physician's lab:**

- ☐ Insulin-like growth factor 1 (IGF-1/somatomedin-C)  
☐ Insulin growth factor binding protein-3 (IGFBP-3)

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests) \*\***

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## Requests for Growth Failure in Children Small for Gestational Age (SGA)

- Is there demonstration of catch up growth failure in the first 24 months of life using a 0-36 month growth chart?  
☐ Yes ☐ No

- Is one of the following below 3<sup>rd</sup> percentile for gestational age (more than 2 SD below population mean):  
☐ Yes ☐ No (check which applies)  
☐ Birth weight ☐ Birth length

- Does the patient's height remain  $\leq 3^{\text{rd}}$  percentile (more than 2 SD below population mean)? ☐ Yes ☐ No  
 If yes, list height: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests)\*\***

## Requests for Turner Syndrome & Noonan Syndrome

- Is the patient's height below the fifth percentile on growth charts for age and gender? ☐ Yes ☐ No  
 If yes, list height: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests)\*\***

## Requests for Short Stature Homeobox (SHOX) Gene Deficiency

- Is the diagnosis confirmed by genetic testing? ☐ Yes ☐ No

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests)\*\***

## Requests for Adult Growth Hormone Deficiency

- Are there clinical records supporting a diagnosis of childhood-onset growth hormone deficiency? ☐ Yes ☐ No

- Are there clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes? ☐ Yes ☐ No  
 If yes, list cause: \_\_\_\_\_

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has undergone one of the following GH stimulation tests to confirm adult GH deficiency: ☐ Yes ☐ No  
☐ Insulin tolerance test (ITT) ☐ Arginine & GHRH (GHRH+ARG)  
☐ Glucagon ☐ Arginine (ARG)

- Did the test result in one of the following peak GH values: ☐ Yes ☐ No  
☐ ITT  $\leq 5\mu\text{g/L}$  ☐ Glucagon  $\leq 3\mu\text{g/L}$   
☐ GHRH+ARG ☐ ARG  $\leq 0.4\mu\text{g/L}$   
 - If patient BMI  $< 25\text{kg/m}^2$ :  $\leq 11\mu\text{g/L}$   
 - If patient BMI  $\geq 25\text{kg/m}^2$  and  $< 30\text{kg/m}^2$ :  $\leq 8\mu\text{g/L}$   
 - If patient BMI  $\geq 30\text{kg/m}^2$ :  $\leq 4\mu\text{g/L}$

If yes, list test and result (and BMI if applicable): \_\_\_\_\_

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of any of the following anterior pituitary hormones: ☐ Yes ☐ No (check all that apply)  
☐ Prolactin ☐ Adrenocorticotrophic hormone (ACTH)  
☐ Thyroid stimulating hormone (TSH) ☐ Follicle-stimulating hormone/luteinizing hormone (FSH/LH)

- Is IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab? ☐ Yes ☐ No If yes, list IGF-1/Somatomedin-C level and date: \_\_\_\_\_

- Will this be used in combination with aromatase inhibitors? ☐ Yes ☐ No

- Will this be used in combination with androgens? ☐ Yes ☐ No

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests)\*\***

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## Requests for Transition Phase Adolescent Patient

- Has the patient attained expected adult height? ☐ Yes ☐ No
- Is there submission of medical records (e.g., chart notes, laboratory values) documenting high risk of Growth Hormone deficiency due to GH deficiency in childhood from one of the following: ☐ Yes ☐ No
  - ☐ Embryopathic/congenital defects
  - ☐ Genetic mutations
  - ☐ Irreversible structural hypothalamic-pituitary disease
  - ☐ Panhypopituitarism
  - ☐ Deficiency of three of the following anterior pituitary hormones:
    - ☐ ACTH ☐ TSH ☐ Prolactin ☐ FSH/LH
- Is IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab? ☐ Yes ☐ No If yes, list IGF-1/Somatomedin-C level and date: \_\_\_\_\_
- Has the patient undergone one of the following GH stimulation tests after discontinuation of GH therapy for at least 1 month? ☐ Yes ☐ No (check which apply) Test Date: \_\_\_\_\_
  - ☐ ITT ☐ GHRH+ARG ☐ ARG ☐ Glucagon
- Did the test result in one of the following peak GH values:
  - ☐ ITT  $\leq 5\mu\text{g/L}$
  - ☐ GHRH+ARG
    - ☐ If patient BMI  $< 25\text{kg/m}^2$ :  $\leq 11\mu\text{g/L}$
    - ☐ If patient BMI  $\geq 25\text{kg/m}^2$  and  $< 30\text{kg/m}^2$ :  $\leq 8\mu\text{g/L}$
    - ☐ If patient BMI  $\geq 30\text{kg/m}^2$ :  $\leq 4\mu\text{g/L}$
  - ☐ Glucagon  $\leq 3\mu\text{g/L}$
  - ☐ ARG  $\leq 0.4\mu\text{g/L}$
- Is the patient at low risk of severe GH deficiency (e.g. due to isolated and/or idiopathic GH deficiency)? ☐ Yes ☐ No  
 \*\*(Refer to the Reauthorization Section for Continuation of Care Requests)\*\*

## Requests for HIV-Associated Cachexia

- Is there documentation of one of the following: ☐ Yes ☐ No (check which apply)
  - ☐ Unintentional weight loss  $>10\%$  over the last 12 months ☐ Unintentional weight loss of  $>7.5\%$  over the last 6 months
  - ☐ Loss of 5% body cell mass (BCM) within 6 months ☐ Body mass index (BMI)  $< 20\text{ kg/m}^2$
- List patient's BMI: \_\_\_\_\_  $\text{kg/m}^2$  & BCM: \_\_\_\_\_ %
- Has a nutritional evaluation has been completed since onset of wasting first occurred? ☐ Yes ☐ No  
Date: \_\_\_\_\_
- Has the patient had weight loss as a result of other underlying treatable conditions? ☐ Yes ☐ No
- Has the patient's anti-retroviral therapy been optimized to decrease the viral load? ☐ Yes ☐ No  
 \*\*(Refer to the Reauthorization Section for Continuation of Care Requests)\*\*

## Requests for Short Bowel Syndrome

- Is the patient currently receiving specialized nutritional support? ☐ Yes ☐ No
- Has the patient previously received 4 weeks of treatment with Zorbtive? ☐ Yes ☐ No  
 \*\*(Refer to the Reauthorization Section for Continuation of Care Requests)\*\*

## Requests for Severe Primary IGF-1 Deficiency/Growth Hormone Gene Deletion

- Does the patient have all of the following: ☐ Yes ☐ No (check which apply)
  - ☐ The patient has developed neutralizing antibodies to growth hormone
  - ☐ Open epiphyses on the last bone radiograph

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- Is there documentation of all of the following: ☐ Yes ☐ No (check which apply)

- ☐ Height standard deviation score  $\leq -3.0$
- ☐ Basal IGF-1 standard deviation score  $\leq -3.0$
- ☐ Normal or elevated growth hormone levels
- ☐ Open epiphyses on the last bone radiograph

- List Height: \_\_\_\_\_ Date: \_\_\_\_\_

- Will the patient be treated with concurrent growth hormone therapy? ☐ Yes ☐ No

**\*\* (Refer to the Reauthorization Section for Continuation of Care Requests)\*\***

## REAUTHORIZATION REQUESTS

### Reauthorization Requests for Pediatric Growth Hormone Deficiency, Growth Failure associated with Chronic Renal Insufficiency, AND Prader-Willi:

- Was there a height increase of at least 2 cm/year over the previous year of treatment as documented by both of the following: ☐ Yes ☐ No

- Previous height and date obtained: \_\_\_\_\_

- Current height and date obtained: \_\_\_\_\_

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting calculated height (growth) velocity over the past 12 months? List height (growth) velocity: \_\_\_\_\_

- Was expected adult height not attained, with documentation of expected adult height goal (e.g. genetic potential)? ☐ Yes ☐ No If yes, list expected adult height goal: \_\_\_\_\_

- Is there evidence of positive response to therapy (e.g. increase in total lean body mass, decrease in fat mass)? ☐ Yes ☐ No If yes, list response: \_\_\_\_\_

### Reauthorization Requests for Growth Failure in Children Small for Gestational Age (SGA)/Turner Syndrome/Noonan Syndrome/Short Stature Homeobox Gene Deficiency (SHOX):

- Was there a height increase of at least 2 cm/year over the previous year of treatment as documented by both of the following: ☐ Yes ☐ No

- Previous height and date obtained: \_\_\_\_\_

- Current height and date obtained: \_\_\_\_\_

- Was expected adult height not attained, with documentation of expected adult height goal (e.g. genetic potential)? ☐ Yes ☐ No If yes, list expected adult height goal: \_\_\_\_\_

### Reauthorization Requests for Adult Growth Hormone Deficiency:

- Is there documentation within the past 12 months of an IGF-1/Somatomedin C level? ☐ Yes ☐ No  
If yes, list level and date: \_\_\_\_\_

### Reauthorization Requests for Transition Phase Adolescent Patient:

- Is there documentation of a positive response to therapy (e.g. increase in total lean body mass, exercise capacity, or IGF-1 and IGFBP-3 levels)? ☐ Yes ☐ No

### Reauthorization Requests for HIV-Associated Cachexia:

- Is there evidence of positive response to therapy (i.e., greater than or equal to 2% increase in body weight and/or BCM)? ☐ Yes ☐ No

- Has one of the following targets or goals not been achieved? ☐ Yes ☐ No (check which apply)

☐ Weight

☐ BCM

☐ BMI

### Reauthorization Requests for Severe Primary IGF-1 Deficiency/Growth Hormone Gene Deletion:

- Was expected adult height not attained, with documentation of expected adult height goal (e.g. genetic potential)? ☐ Yes ☐ No If yes, list expected adult height goal: \_\_\_\_\_

**Human Growth Hormone,  
Growth Stimulating Products - Arizona  
PRIOR AUTHORIZATION REQUEST FORM**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<p><b>- Was there a height increase of at least 2 cm/year over the previous year of treatment as documented by both of the following:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;"><b>-Previous height and date obtained:</b> _____</p> <p style="margin-left: 20px;"><b>-Current height and date obtained:</b> _____</p>		

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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