UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

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.uhcprovider.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**: Initial here if DAW:

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 continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? ☐ Yes ☐ No

****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 ☐

UnitedHealthcare Community Plan

Growth Hormone - Pennsylvania

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 Information:		

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 - Provider 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:	**Quantity:**
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

Medications	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 at www.uhcprovider.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Growth Hormone - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

	ALL REQUESTS
	Document the patient's weight: _____ lbs/kg
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ AIDS related cachexia □ Growth hormone deficiency (for patients 18 years of age and older or at any age with closed epiphyses) □ Neonate growth hormone deficiency □ Pediatric growth hormone deficiency
□ **Yes** □ **No**	**Is the requested medication prescribed by one of the following specialists?** *(If yes, check which applies)* □ Endocrinologist □ Neonatologist (in the neonatal period) □ Other: _____
□ **Yes** □ **No**	**Does the patient have contraindications to growth hormone?**
□ **Yes** □ **No**	**Has the patient had appropriate imaging (magnetic resonance imaging [MRI] or computed tomography [CT]) of the brain with particular attention to the hypothalamic pituitary region to exclude the possibility of a tumor?**
□ **Yes** □ **No**	**Does the patient have a history of therapeutic failure of the preferred growth hormones?** *(If yes, complete Section D above)*
	AIDS RELATED CACHEXIA
□ **Yes** □ **No**	**Does the patient have a diagnosis of wasting syndrome and the wasting syndrome is not attributable to other causes such as depression, MAC, chronic infectious diarrhea, or malignancy (NOTE: Kaposi's sarcoma limited to the skin or mucous membranes is covered)?**
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies)* □ Body mass index (BMI) of less than or equal to 18.5 □ BMI of less than or equal to 25 □ An unintentional or unexplained weight loss of five percent in one month, seven and a half percent in three months, or ten percent in six months
□ **Yes** □ **No**	**Does the patient have a history of inadequate response or intolerance to acquired immunodeficiency syndrome (AIDS)-related cachexia treatment options, such as but not limited to: Nutritional supplements that increase caloric and protein intake and steroid hormones such as megestrol?** *(If yes, complete Section D above)*
	GROWTH HORMONE DEFICIENCY (for patients 18 years of age and older or at any age with closed epiphyses)
□ **Yes** □ **No**	**Does the patient have documented history of adult growth hormone deficiency as a result of any of the following?** *(If yes, check which applies)* □ Childhood onset growth hormone deficiency □ Pituitary or hypothalamic disease □ Surgery or radiation therapy □ Trauma
□ **Yes** □ **No**	**Does the patient have two stimulation tests (repeated in adulthood if the patient had testing as a child), showing growth hormone deficiency (defined as a peak growth hormone level of less than 5 ng/ml (nanograms per milliliter)?** *Testing must use insulin to induce hypoglycemia as one of the agents (unless contraindicated) and the patient must have at least a one-month drug holiday from growth hormone if previously treated during childhood. Provocative testing with levodopa, arginine, clonidine, glucagon, or propranolol, will be accepted as the second agent and as a first agent in patients with a contraindication to insulin tolerance testing*
□ **Yes** □ **No**	**Does the patient have panhypopituitarism (as defined by 3 or more deficient pituitary hormones in addition to growth hormone) or a structural abnormality in the area of the hypothalamus or pituitary, with a low IGF-1 measured at least one month after stopping prior growth hormone therapy?**
□ **Yes** □ **No**	**Is the patient currently receiving replacement therapy for any other pituitary hormone deficiencies that is consistent with current medical standards of practice?**
□ **Yes** □ **No**	**For traumatic brain injury or subarachnoid hemorrhage patients, will stimulation testing be obtained at least 12 months from the date of injury?**

UnitedHealthcare Community Plan

Growth Hormone - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

	NEONATE GROWTH HORMONE DEFICIENCY
□ **Yes** □ **No**	**Does the patient have documented history of hypoglycemia with no metabolic disorder?**
□ **Yes** □ **No**	**Has the patient's cortisol, adrenocorticotropic hormone (ACTH), thyroid- stimulating hormone (TSH) and thyroxine levels been evaluated and treated if deficient?**
□ **Yes** □ **No**	**Does the patient have a growth hormone level of less than 20 ng/mL (nanograms per milliliter)?**
	PEDIATRIC GROWTH HORMONE DEFICIENCY (cont'd on the next page)
□ **Yes** □ **No**	**Does the patient have confirmed open epiphyses?**
□ **Yes** □ **No**	**Is the patient Tanner stage 3 or greater?**
□ **Yes** □ **No**	**Does the patient have a diagnosis of pediatric growth hormone deficiency as documented by any of the following?** *(If yes, check which applies)* □ Height greater than 2 standard deviations (SD) below the age related mean □ Provocative stimulation tests producing peak growth hormone concentrations less than 10ng/ml (nanograms per milliliter)
□ **Yes** □ **No**	**Does the patient have significant structural abnormality such as pituitary stalk agenesis or empty sella with low insulin-like growth factor (IGF-1) and 1 provocative stimulation test producing peak growth hormone concentrations less than 10 ng/ml (nanograms per milliliter)?**
□ **Yes** □ **No**	**Does the patient have panhypopituitarism (as defined by 3 or more deficient pituitary hormones in addition to growth hormone) with a low IGF-1?**
□ **Yes** □ **No**	**Does the patient have a low IGF-1 with any of the following?** *(If yes, check which applies)* □ Height is greater than 2.25 SD below the mean for age or greater than 2 SD below the midparental height percentile □ Growth velocity is less than 25th percentile for bone age □ A history of having passed growth hormone stimulation tests
□ **Yes** □ **No**	**Is the patient's growth failure due to idiopathic short stature, familial short stature, or constitutional growth delay?**
□ **Yes** □ **No**	**Have other causes for short stature have been excluded?**
□ **Yes** □ **No**	**Does the patient have a diagnosis of pediatric growth failure, defined as height greater than 2 standard deviations (SD) below the age related mean, due to chronic renal failure and the patient has not undergone a renal transplant?**
□ **Yes** □ **No**	**Was the patient born small for gestational age (SGA), defined as having a birth weight less than 2500 grams at a gestational age of 37 weeks and older, or weight or length at birth greater than 2 standard deviations below the mean for gestational age?**
□ **Yes** □ **No**	**Has the patient failed to manifest catch up growth by 2 year of age, defined as height 2 or more standard deviations below the mean for age and gender?**
□ **Yes** □ **No**	**Does the patient have growth failure defined as height greater than 2 standard deviations (SD) below the age related mean due to a diagnosis of Turner's syndrome as documented by genetic testing consistent with Turner's syndrome?**
□ **Yes** □ **No**	**Does the patient have growth failure defined as height greater than 2 standard deviations (SD) below the age related mean due to a diagnosis of Noonan's syndrome as documented by any of the following?** *(If yes, check which applies)* □ Confirmed positive genetic testing for Noonan syndrome □ Clinical observation of ALL of the following key features: □ Short stature □ Developmental delay of variable degree □ Cryptorchidism in males □ Coagulation defects or disordered bleeding □ Feeding difficulty □ Abnormality of the cardiovascular system □ Broad or webbed neck □ Characteristic facies □ Neurologic abnormality such as seizure or hypotonia □ Ocular problems □ Oral findings such as high arched palate, dental malocclusion or articulation difficulty □ Unusual chest shape with superior pectus carinatum, inferior pectus excavatum and apparently low-set nipples □ Peripheral lymphedema

UnitedHealthcare Community Plan

Growth Hormone - Pennsylvania

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Does the patient have a diagnosis of Prader-Willi syndrome, as documented by genetic testing consistent with Prader-Willi syndrome?**
□ Yes □ No	**Is the patient receiving treatment for Prader-Willi syndrome?**
□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies)* □ Has no symptoms of sleep apnea □ Has a history of sleep apnea or symptoms consistent with sleep apnea and has been fully evaluated and treated
CONTINUATION OF THERAPY - AIDS RELATED CACHEXIA	
□ Yes □ No	**Does the patient have presence of weight stabilization or increase?**
CONTINUATION OF THERAPY- GROWTH HORMONE DEFICIENCY (for patients 18 years of age and older or at any age with closed epiphyses)	
□ Yes □ No	**Does the patient have presence of a clinical benefit of the growth hormone such as increase in total lean body mass, increase in exercise capacity or improved energy level?**
□ Yes □ No	**Is there demonstration of compliance?**
□ Yes □ No	**Does the patient have a normal insulin-like growth factor (IGF-1)?**
CONTINUATION OF THERAPY - NEONATE GROWTH HORMONE DEFICIENCY	
□ Yes □ No	**Does the patient have an insulin-like growth factor (IGF-1) concentration in the normal range for age and gender?**
CONTINUATION OF THERAPY - PEDIATRIC GROWTH HORMONE DEFICIENCY	
□ Yes □ No	**Does the patient demonstrate a growth response equal to or greater than 4.5 centimeters per year (cm/yr) (pre-pubertal growth rate) or equal to or greater than 2.5 cm/yr (post-pubertal growth rate)?**
□ Yes □ No	**Does the patient have an insulin-like growth factor (IGF-1) concentration in the normal range for age and gender?**
□ Yes □ No	**Has the patient reached their expected final adult height (defined as mid-parenteral height)?**
□ Yes □ No	**For a diagnosis of Prader-Willi syndrome, has the patient's lean to fat body mass or growth velocity improved?**

Physician Signature: _____ **Date:** _____