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.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 ☐

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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:	**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 for a list of preferred alternatives

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Clinical and Drug Specific Information

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

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

□ Pediatric growth hormone deficiency
□ Growth failure in children small for gestational age (SGA)
□ Noonan syndrome
□ Transition phase adolescent patient
□ Severe primary IGF-1 deficiency
□ Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency
□ Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
□ Prader-Willi syndrome
□ Turner syndrome (gonadal dysgenesis)
□ Adult growth hormone deficiency
□ Short bowel syndrome
□ Growth hormone gene deletion
□ Pediatric growth failure associated with chronic renal insufficiency
□ 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 (GHD)

- 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 <u>any</u> 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

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- 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)

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 3rd 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 ≤ 3rd percentile (more than 2 SD below population mean)? □ Yes □ No
If yes, list height: _____ Date: _____

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: _____

Requests for Short Stature Homeobox (SHOX) Gene Deficiency

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

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 <u>one</u> of the following GH stimulation tests to confirm adult GH deficiency: □ Yes □ No
□ Insulin tolerance test (ITT)
□ Glucagon
□ Macrilen (macimorelin)
□ Arginine & GHRH (GHRH+ARG)
□ Arginine (ARG)

- Did the test result in one of the following peak GH values: □ Yes □ No
□ ITT ≤ 5µg/L
□ GHRH+ARG
- If patient BMI < 25kg/m^2: ≤ 11µg/L
- If patient BMI ≥ 25kg/m^2 and <30kg/m^2: ≤ 8µg/L
- If patient BMI ≥ 30kg/m^2: ≤4µg/L

□ Glucagon ≤ 3µg/L
□ ARG ≤ 0.4µg/L
□ Macimorelin < 2.8 ng/mL 30, 45, 60, and 90 minutes following macimorelin administration

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
□ Thyroid stimulating hormone (TSH)
□ Adrenocorticotropic hormone (ACTH)
□ 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

Requests for Transition Phase Adolescent Patient

- Has the patient attained expected adult height? □ Yes □ No

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- 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

- 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 ≤ 5µg/L
□ GHRH+ARG
- If patient BMI < 25kg/m^2: ≤ 11µg/L
- If patient BMI ≥ 25kg/m^2 and <30kg/m^2: ≤ 8µg/L
- If patient BMI ≥ 30kg/m^2: ≤4µg/L

□ Glucagon ≤ 3µg/L
□ ARG ≤ 0.4µg/L

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

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
□ Loss of 5% body cell mass (BCM) within 6 months
□ Unintentional weight loss of >7.5% over the last 6 months
□ Body mass index (BMI) < 20 kg/m^2

- List patient's BMI: _____ kg/m^2 & BCM: _____ %

- Has a nutritional evaluation has been completed since onset of wasting first occurred? □ Yes □ No
Date of Evaluation: _____

- 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

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

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

- Is there documentation of all of the following: □ Yes □ No (check which apply)
□ Height standard deviation score ≤ -3.0
□ Basal IGF-1 standard deviation score ≤ -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

- 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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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? □ Yes □ No**
  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: _____
- **Does the patient have a diagnosis of panhypopituitarism?**
- **Will this be used in combination with aromatase inhibitors?**
- **Will this be used in combination with androgens?**

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 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: _____

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Reauthorization Requests for SEVERE PRIMARY IGF-1 DEFICIENCY/GROWTH HORMONE GENE DELETION: (cont'd)

- 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: _____

Physician Signature: _____ Date: _____