

**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](http://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

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](http://www.uhcprovider.com) for a list of preferred alternatives**

|                    |                   |             |
|--------------------|-------------------|-------------|
| Member First name: | Member Last name: | Member DOB: |
|--------------------|-------------------|-------------|

**Clinical and Drug Specific Information**

**ALL REQUESTS**

|   |   |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
|---|---|--|--|---|--|---|--|---|--|--|---|---|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No  | <p><b>Does the patient have any of the following diagnoses?</b> <i>(If yes, check which applies)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> Adult growth hormone deficiency</td> <td style="width:50%; border: none;"><input type="checkbox"/> Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Growth hormone gene deletion</td> <td style="border: none;"><input type="checkbox"/> Pediatric growth hormone deficiency (GHD)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Growth failure in children small for gestational age (SGA)</td> <td style="border: none;"><input type="checkbox"/> Prader-Willi syndrome</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia</td> <td style="border: none;"><input type="checkbox"/> Severe primary IGF-1 deficiency</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Noonan syndrome</td> <td style="border: none;"><input type="checkbox"/> Short bowel syndrome</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency</td> <td style="border: none;"><input type="checkbox"/> Transition phase adolescent patient</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Other. Please specify: _____</td> <td style="border: none;"><input type="checkbox"/> Turner syndrome (Gonadal dysgenesis)</td> </tr> </table> | <input type="checkbox"/> Adult growth hormone deficiency | <input type="checkbox"/> Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency | <input type="checkbox"/> Growth hormone gene deletion | <input type="checkbox"/> Pediatric growth hormone deficiency (GHD) | <input type="checkbox"/> Growth failure in children small for gestational age (SGA) | <input type="checkbox"/> Prader-Willi syndrome | <input type="checkbox"/> Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia | <input type="checkbox"/> Severe primary IGF-1 deficiency | <input type="checkbox"/> Noonan syndrome | <input type="checkbox"/> Short bowel syndrome | <input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency | <input type="checkbox"/> Transition phase adolescent patient | <input type="checkbox"/> Other. Please specify: _____ | <input type="checkbox"/> Turner syndrome (Gonadal dysgenesis) |
| <input type="checkbox"/> Adult growth hormone deficiency  | <input type="checkbox"/> Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency  |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
| <input type="checkbox"/> Growth hormone gene deletion   | <input type="checkbox"/> Pediatric growth hormone deficiency (GHD)  |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
| <input type="checkbox"/> Growth failure in children small for gestational age (SGA)                 | <input type="checkbox"/> Prader-Willi syndrome  |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
| <input type="checkbox"/> Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia | <input type="checkbox"/> Severe primary IGF-1 deficiency  |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
| <input type="checkbox"/> Noonan syndrome  | <input type="checkbox"/> Short bowel syndrome   |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
| <input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency       | <input type="checkbox"/> Transition phase adolescent patient  |  |  |   |  |   |  |   |  |  |   |   |  |   |   |
| <input type="checkbox"/> Other. Please specify: _____   | <input type="checkbox"/> Turner syndrome (Gonadal dysgenesis)   |  |  |   |  |   |  |   |  |  |   |   |  |   |   |

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Does the patient have a diagnosis of panhypopituitarism?</b> |
|--|---|

|  |   |  |                                       |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p><b>Is the requested medication prescribed by any of the following?</b> <i>(If yes, check which applies)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> Endocrinologist</td> <td style="width:50%; border: none;"><input type="checkbox"/> Nephrologist</td> </tr> </table> | <input type="checkbox"/> Endocrinologist | <input type="checkbox"/> Nephrologist |
| <input type="checkbox"/> Endocrinologist                 | <input type="checkbox"/> Nephrologist   |  |                                       |

Document the patient's Tanner stage: \_\_\_\_\_

Document the patient's bone age: \_\_\_\_\_ Date of Bone Age Study: \_\_\_\_\_

Document the patient's weight: \_\_\_\_\_ Kg

|  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p><b>If the request is for a non-preferred medication, is there a reason or special circumstance that the patient must be treated with a non-preferred medication?</b></p> <p><i>If yes, provide reason/special circumstance:</i></p> |
|--|--|

**ADULT GROWTH HORMONE DEFICIENCY (Continued on next page)**

|  |   |   |  |  |  |
|--|---|---|--|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No   | <p><b>Was the diagnosis of adult growth hormone deficiency (GHD) a result of any of the following?</b> <i>(If yes, check which applies)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> Clinical records supporting a diagnosis of childhood-onset GHD</td> <td style="width:50%; border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Adult-onset GHD - 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)</td> <td style="border: none;"></td> </tr> </table> | <input type="checkbox"/> Clinical records supporting a diagnosis of childhood-onset GHD |  | <input type="checkbox"/> Adult-onset GHD - 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) |  |
| <input type="checkbox"/> Clinical records supporting a diagnosis of childhood-onset GHD  |   |   |  |  |  |
| <input type="checkbox"/> Adult-onset GHD - 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) |   |   |  |  |  |

|  |  |   |   |  |                                   |   |   |
|--|--|---|---|--|-----------------------------------|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <p><b>Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has undergone any of the following GH stimulation tests to confirm adult GH deficiency?</b> <i>(If yes, check which applies. DOCUMENTATION REQUIRED)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:33%; border: none;"><input type="checkbox"/> Arginine (ARG)</td> <td style="width:33%; border: none;"><input type="checkbox"/> ARG (Arginine) and GHRH (growth hormone releasing hormone)</td> <td style="width:33%; border: none;"></td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Glucagon</td> <td style="border: none;"><input type="checkbox"/> Insulin tolerance test (ITT)</td> <td style="border: none;"><input type="checkbox"/> Macrilen (macimorelin)</td> </tr> </table> | <input type="checkbox"/> Arginine (ARG)         | <input type="checkbox"/> ARG (Arginine) and GHRH (growth hormone releasing hormone) |  | <input type="checkbox"/> Glucagon | <input type="checkbox"/> Insulin tolerance test (ITT) | <input type="checkbox"/> Macrilen (macimorelin) |
| <input type="checkbox"/> Arginine (ARG)                  | <input type="checkbox"/> ARG (Arginine) and GHRH (growth hormone releasing hormone)  |   |   |  |                                   |   |   |
| <input type="checkbox"/> Glucagon                        | <input type="checkbox"/> Insulin tolerance test (ITT)  | <input type="checkbox"/> Macrilen (macimorelin) |   |  |                                   |   |   |

|   |  |                                      |   |                                   |  |   |  |   |  |   |  |
|---|--|--------------------------------------|---|-----------------------------------|--|---|--|---|--|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No                | <p><b>Did the test result in any of the following peak GH values?</b> <i>(If yes, check which applies)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> ITT ≤ 5µg/L</td> <td style="width:50%; border: none;"><input type="checkbox"/> Glucagon ≤ 3µg/L</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> GHRH+ARG</td> <td style="border: none;"><input type="checkbox"/> ARG ≤ 0.4µg/L</td> </tr> <tr> <td style="border: none;">- ≤ 11µg/L if patient BMI &lt; 25kg/m<sup>2</sup></td> <td style="border: none;"><input type="checkbox"/> Macimorelin &lt; 2.8 ng/mL 30, 45, 60, and 90 minutes following macimorelin administration</td> </tr> <tr> <td style="border: none;">- ≤ 8µg/L if patient BMI ≥ 25kg/m<sup>2</sup> and &lt;30kg/m<sup>2</sup></td> <td style="border: none;"></td> </tr> <tr> <td style="border: none;">- ≤4µg/L if patient BMI ≥ 30kg/m<sup>2</sup></td> <td style="border: none;"></td> </tr> </table> <p><b>If yes, list test and result (and BMI if applicable):</b> _____</p> | <input type="checkbox"/> ITT ≤ 5µg/L | <input type="checkbox"/> Glucagon ≤ 3µg/L | <input type="checkbox"/> GHRH+ARG | <input type="checkbox"/> ARG ≤ 0.4µg/L | - ≤ 11µg/L if patient BMI < 25kg/m <sup>2</sup> | <input type="checkbox"/> Macimorelin < 2.8 ng/mL 30, 45, 60, and 90 minutes following macimorelin administration | - ≤ 8µg/L if patient BMI ≥ 25kg/m <sup>2</sup> and <30kg/m <sup>2</sup> |  | - ≤4µg/L if patient BMI ≥ 30kg/m <sup>2</sup> |  |
| <input type="checkbox"/> ITT ≤ 5µg/L                                    | <input type="checkbox"/> Glucagon ≤ 3µg/L  |                                      |   |                                   |  |   |  |   |  |   |  |
| <input type="checkbox"/> GHRH+ARG                                       | <input type="checkbox"/> ARG ≤ 0.4µg/L   |                                      |   |                                   |  |   |  |   |  |   |  |
| - ≤ 11µg/L if patient BMI < 25kg/m <sup>2</sup>                         | <input type="checkbox"/> Macimorelin < 2.8 ng/mL 30, 45, 60, and 90 minutes following macimorelin administration   |                                      |   |                                   |  |   |  |   |  |   |  |
| - ≤ 8µg/L if patient BMI ≥ 25kg/m <sup>2</sup> and <30kg/m <sup>2</sup> |  |                                      |   |                                   |  |   |  |   |  |   |  |
| - ≤4µg/L if patient BMI ≥ 30kg/m <sup>2</sup>                           |  |                                      |   |                                   |  |   |  |   |  |   |  |

|  |  |  |                                    |  |  |
|--|--|--|------------------------------------|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No                           | <p><b>Will medical records (e.g., chart notes, laboratory values) be submitted documenting deficiency of any of the following anterior pituitary hormones?</b> <i>(If yes, check which applies. DOCUMENTATION REQUIRED)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> ACTH (adrenocorticotrophic hormone)</td> <td style="width:50%; border: none;"><input type="checkbox"/> Prolactin</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> FSH/LH (follicle-stimulating hormone/luteinizing hormone)</td> <td style="border: none;"><input type="checkbox"/> TSH (thyroid stimulating hormone)</td> </tr> </table> | <input type="checkbox"/> ACTH (adrenocorticotrophic hormone) | <input type="checkbox"/> Prolactin | <input type="checkbox"/> FSH/LH (follicle-stimulating hormone/luteinizing hormone) | <input type="checkbox"/> TSH (thyroid stimulating hormone) |
| <input type="checkbox"/> ACTH (adrenocorticotrophic hormone)                       | <input type="checkbox"/> Prolactin   |  |                                    |  |  |
| <input type="checkbox"/> FSH/LH (follicle-stimulating hormone/luteinizing hormone) | <input type="checkbox"/> TSH (thyroid stimulating hormone)   |  |                                    |  |  |

|   |  |                    |
|---|--|--------------------|
| <b>Member First name:</b>   | <b>Member Last name:</b>   | <b>Member DOB:</b> |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Is the Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab?</b><br><i>If yes, list IGF-1/Somatomedin-C level and date:</i>   |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Will the requested medication be used in combination with any of the following?</b><br><i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]</li> <li><input type="checkbox"/> Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]</li> </ul>   |                    |
| <b>GROWTH FAILURE IN CHILDREN SMALL FOR GESTATIONAL AGE (SGA)</b>                 |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Was the diagnosis of SGA (small for gestational age) based on demonstration of catch up growth failure in the first 24 months of life using a birth to 36 month growth chart as confirmed by any of the following?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Documentation that birth weight or birth length is below the third percentile for gestational age (greater than or equal to 2 standard deviations [SD] below population mean)</li> <li><input type="checkbox"/> Patient has demonstrated failure of catch up growth in the first 24 months of life</li> </ul>   |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Is there documentation that the patient's height remains less than or equal to third percentile (greater than or equal to 2 SD below population mean)?</b>  |                    |
| <b>GROWTH HORMONE GENE DELETION</b>   |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Has the patient developed neutralizing antibodies to growth hormone?</b>  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Is there documentation of open epiphyses on last bone radiograph?</b>   |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Will the patient be treated with concurrent growth hormone therapy?</b>   |                    |
| <b>HIV – ASSOCIATED WASTING SYNDROME OR CACHEXIA</b>                              |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Is there documentation of any of the following?</b> <i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Body mass index (BMI) less than 20 kg/m<sup>2</sup></li> <li><input type="checkbox"/> Loss of 5% body cell mass (BCM) within 6 months</li> <li><input type="checkbox"/> Unintentional weight loss of greater than 7.5% over the last 6 months</li> <li><input type="checkbox"/> Unintentional weight loss greater than 10% over the last 12 months</li> </ul>  |                    |
| <b>Document patient's BMI: _____ kg/m<sup>2</sup> &amp; BCM: _____%</b>           |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Has a nutritional evaluation been completed since onset of wasting first occurred?</b>  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Has the patient had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)?</b>  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Has the patient's anti-retroviral therapy been optimized to decrease the viral load?</b>  |                    |
| <b>NOONAN SYNDROME OR TURNER SYNDROME</b>   |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Is the patient's height below the fifth percentile on growth charts for age and gender?</b>   |                    |
| <b>PEDIATRIC GROWTH FAILURE WITH SHORT-STATURE HOMEBOX (SHOX) GENE DEFICIENCY</b> |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Was the diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency confirmed by genetic testing?</b>  |                    |
| <b>PEDIATRIC GROWTH HORMONE DEFICIENCY <i>(Continued on next page)</i></b>        |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Is the infant less than 4 months of age with growth deficiency?</b>   |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Does the patient have a history of neonatal hypoglycemia associated with pituitary disease?</b>   |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No                          | <b>Was the diagnosis of pediatric growth hormone deficiency confirmed by any of the following?</b><br><i>(If yes, check which applies)</i> <ul style="list-style-type: none"> <li><input type="checkbox"/> Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height</li> <li><input type="checkbox"/> Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height</li> <li><input type="checkbox"/> Growth velocity is greater than 2 SD below mean for age and gender</li> <li><input type="checkbox"/> Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)</li> </ul> |                    |



|                    |                   |             |
|--------------------|-------------------|-------------|
| Member First name: | Member Last name: | Member DOB: |
|--------------------|-------------------|-------------|

**CONTINUATION OF THERAPY – ADULT GROWTH HORMONE DEFICIENCY**

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Is there documentation of an IGF-1/Somatomedin C level within the past 12 months?</b><br><i>If yes, list IGF-1/Somatomedin-C level and date:</i>   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Will the requested medication be used in combination with any of the following?</b><br><i>(If yes, check which applies)</i><br><input type="checkbox"/> Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)]<br><input type="checkbox"/> Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)] |

**CONTINUATION OF THERAPY –  
GROWTH FAILURE IN CHILDREN SMALL FOR GESTATIONAL AGE (SGA) / NOONAN SYNDROME /  
PEDIATRIC GROWTH FAILURE ASSOCIATED WITH CHRONIC RENAL INSUFFICIENCY / PEDIATRIC GROWTH  
FAILURE WITH SHORT-STATURE HOMEBOX (SHOX) GENE DEFICIENCY / TURNER SYNDROME**

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was there a height increase of at least 2 cm/year over the previous year?</b><br><i>If yes, document the following:</i><br><u>Previous</u> height and date obtained: _____<br><u>Current</u> height and date obtained: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was the expected adult height attained?</b><br><i>If NO, please document expected adult height goal:</i>   |

**CONTINUATION OF THERAPY - GROWTH HORMONE GENE DELETION & SEVERE PRIMARY IGF-1 DEFICIENCY**

|  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Will the patient be treated with concurrent growth hormone therapy?</b>   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was there a height increase of at least 2 cm/year over the previous year of treatment?</b><br><i>If yes, document the following:</i><br><u>Previous</u> height and date obtained: _____<br><u>Current</u> height and date obtained: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was the expected adult height attained?</b><br><i>If NO, please document expected adult height goal:</i>  |

**CONTINUATION OF THERAPY - HIV – ASSOCIATED WASTING SYNDROME OR CACHEXIA**

|  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Is there evidence of positive response to therapy (i.e., greater than or equal to 2% increase in body weight and/or body cell mass)?</b>  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Has any of the following targets or goals <u>not</u> been achieved?</b> <i>(If yes, check which applies)</i><br><input type="checkbox"/> BCM <input type="checkbox"/> BMI <input type="checkbox"/> Weight |

**CONTINUATION OF THERAPY - PEDIATRIC GROWTH HORMONE DEFICIENCY**

Document the patient’s calculated height (growth) velocity over the past 12 months: \_\_\_\_\_

|  |   |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was there a height increase of at least 2 cm/year over the previous year?</b><br><i>If yes, document the following:</i><br><u>Previous</u> height and date obtained: _____<br><u>Current</u> height and date obtained: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was the expected adult height attained?</b><br><i>If NO, please document expected adult height goal (e.g., genetic potential):</i>   |

**CONTINUATION OF THERAPY- PRADER-WILLI SYNDROME**

|  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Is there evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)?</b>   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was there a height increase of at least 2 cm/year over the previous year of treatment?</b><br><i>If yes, document the following:</i><br><u>Previous</u> height and date obtained: _____<br><u>Current</u> height and date obtained: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <b>Was the expected adult height attained?</b><br><i>If NO, please document expected adult height goal:</i>  |



|   |  |                    |
|---|--|--------------------|
| <b>Member First name:</b>   | <b>Member Last name:</b>   | <b>Member DOB:</b> |
| <b>CONTINUATION OF THERAPY - TRANSITION PHASE ADOLESCENT PATIENTS</b> |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No              | <b>Is there documentation of a positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 [Insulin-like Growth Factor 1] and IGFBP-3 [Insulin-like growth factor binding protein 3] levels)?</b> |                    |

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

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