

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

**Growth Hormone,
Growth Stimulating Products - Washington
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 - 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:	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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Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information
(Refer to Section 11 for Reauthorization Requests)

1. All Requests including Prader-Willi

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

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

- Patient's BMI: _____

- Does the patient have open epiphyses? Yes No

- Has the patient demonstrated failure or intolerance to any of the preferred alternatives for the given diagnosis?

- Yes No N/A (No preferred formulary alternatives available)

(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

If no, list reason: _____

- 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: _____

1. Requests for Pediatric Growth Hormone Deficiency

- Does the patient have one of the following diagnoses? Yes No (check which applies)

- Less than 4 months of age with growth deficiency
 History of neonatal hypoglycemia associated with pituitary disease
 Panhypopituitarism
 None of the above

- Is the patient's diagnosis confirmed by one of the following? Yes No (check which applies)

- Projected height is > 2.0 standard deviations (SD) below mid-parental height
 List height and SD below mid-parental height: _____
- Height is > 2.25 SD below population mean
 List height and SD below population mean: _____
- Growth velocity is > 2 SD below mean
 List growth velocity and SD below mean: _____
- Delayed skeletal maturation of > 2 SD below mean
 List skeletal maturation SD below mean: _____
- None of the above

- 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)

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- 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**

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

- Is the diagnosis based on demonstration of catch up growth failure in the first 24 months of life? Yes No**
- Is there documentation that one of the following is ≥ 2 standard deviations (SD) below mean for gestational age?**
- Yes No (If yes, fill in portion below)
 Birth weight, List weight and SD below mean: _____
 Birth length, List length and SD below mean: _____
 None of the above

3. Requests for Turner Syndrome & Noonan Syndrome

- Does the patient meet one of the following: Yes No (check which applies)**
- Standing height > 3 standard deviations (SD) below mean
 List standing height and SD below mean: _____
 Standing height 2-3 SD below mean with deceleration of 2 heights measured by endocrinologist at least 6 months apart (≥ 1 year) or 4 heights measured by primary physician at least 6 months apart (≥ 2 years)
 List all height and SD measurements: _____
 Growth velocity of 2 SD below the mean over 1 year
 List growth velocity, dates, and SD below mean: _____
 None of the above

4. Requests for Short Stature Homeobox (SHOX) Gene Deficiency

- Does the patient have a diagnosis of pediatric growth failure with SHOX gene deficiency as confirmed by genetic testing? Yes No**

5. Requests for Growth Failure Associated with Chronic Renal Insufficiency

- Does the patient have one of the following: Yes No**
- Structural or functional abnormalities of the kidney for ≥ 3 months
 List dates: _____
 GFR < 60 mL/min per $1.73m^2$ for ≥ 3 months
 List GFR and dates: _____
 Occurrence of one each of the above together for any duration of time
 List GFR and dates: _____
 None of the above

6. 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)
- 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)

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- **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 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: _____
- **Does the patient have a diagnosis of panhypopituitarism?** Yes No
- **Will this be used in combination with any of the following:** Yes No **(check all that apply)**
 - Aromatase inhibitors Androgens

7. Requests for HIV-Associated Wasting/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
 - Body mass index (BMI) $< 20 \text{ kg/m}^2$
- **List patient's weight:** _____ kg/m^2 **& Weight loss percentage:** _____ %
- **Has the patient's anti-retroviral therapy been optimized to decrease the viral load?** Yes No
- **Has the patient had weight loss as a result of other underlying treatable conditions?** Yes No
List other conditions: _____
- **Have treatment therapies other than growth hormone been suboptimal?** Yes No (If yes, complete Section D above with medication information, including therapies, dates of trial, and reason for discontinuation)
- **Has a nutritional evaluation has been completed since onset of wasting first occurred?** Yes No
Date: _____
- **Is this prescribed by or in consultation with a physician specializing in HIV diagnosis and management?** Yes No

8. Requests for Short Bowel Syndrome

- **Is the patient currently receiving specialized nutritional support?** Yes No

Physician Signature: _____ **Date:** _____

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