Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Growth Hormone & Growth Stimulating Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Chart notes that include weight, height, growth velocity and lab values (GH levels, IGF-1 / IGFBP-3), stim test results, bone age

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information					
Preferred Agents:	☐ Genotropin or Genotropin MiniQuick	☐ Norditropin FlexPro			
Non-Preferred Agents:	☐ Humatrope	☐ Increlex	☐ Ngenla	☐ Nutroprin AQ Nuspin	☐ Omnitrope
	☐ Saizen	☐ Serostim	☐ Skytrofa	☐ Sogroya	☐ Zomacton
	☐ Zorbtive	☐ Other Please Specify:			

Are there any contraindications to formulary medications? (if yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy

Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	What medication(s) have been tried and failed for this diagnosis? (please specify):
What is the diagnosis ICD-10 Code?	Diagnosis:

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information			
☐ **Pediatric Growth Hormone Deficiency**			
Current height:	Date Obtained:		
☐ Does the member have history of neonatal hypoglycemia associated with pituitary disease?		☐ Yes	☐ No
DX is pediatric GH deficiency confirmed by ONE of the following:	☐ Projected height >2 SD below mid-parental height using age AND gender growth charts related to height		
	☐ Height is >2.25 SD below population mean using age and gender growth charts related to height		
	☐ Growth velocity is >2 SD below mean for age and gender		
	☐ Delayed skeletal maturation >2 SD below mean for age AND gender		

☐ Male with bone age <16 years?	☐ Female with bone age <14 years?
Documentation of TWO of the following GH stimulating tests with BOTH response values <10 mcg/L?	☐ Arginine ☐ Clonidine ☐ GH releasing hormone ☐ Levodopa ☐ Glucagon ☐ Insulin
Age <1 year AND IGF-1 OR IGFBP-3 is below age AND gender adjusted normal range as provided by physician's lab	☐ Yes ☐ No
Does dosing exceed MAX supply limit of 0.3 mg/kg/wk? ☐ Yes ☐ No	Is staging at Tanner Stage 3 or greater AND dosing does NOT exceed MAX supply limit of 0.7 mg/kg/wk? ☐ Yes ☐ No

☐ **Renewal Request ONLY:**

Documentation of height increase by at least 2cm/yr:

current height _____ date obtained: _____

Is there documentation showing expected adult height not attained? ☐ Yes ☐ No	Is there documentation of expected adult height goal (genetic potential)?	☐ Yes	☐ No	
Documentation of calculated height GV over the past 12 months?		☐ Yes	☐ No	
Male with bone <16 years? ☐ Yes ☐ No ☐ N/A	Female with bone age <14 years? ☐Yes	☐ No	☐ N/A	
Does dosing exceed a MAX supply limit of 0.3mg/kg/wk? ☐ Yes ☐ No	Is staging at Tanner Stage 3 or greater AND dosing does NOT exceed MAX supply limit of 0.7mg/kg/wk?	☐ Yes	☐ No	

☐ **Prader-Willi Syndrome**

Current Height: _____ Date obtained: _____

☐ **Renewal Request ONLY:**

Is there documentation of evidence of positive response to therapy (increase in total lean body mass, decrease in fat mass)?	☐ Yes	☐ No
Is there documentation of height increase by at least 2cm/yr over the previous year of TX?		
Current height: _____ Date obtained: _____		
Is there documentation showing expected adult height not attained? ☐ Yes ☐ No	Is there documentation of expected adult height goal (genetic potential)? ☐ Yes	☐ No

☐ **Turner Syndrome**

Diagnosis of pediatric growth failure associated with Turner Syndrome? ☐ Yes ☐ No	Is the member a female AND bone age is <14 years? ☐Yes	☐No
Height is below the 5th percentile on growth charts for age AND gender?	☐Yes	☐No

☐ **Renewal Request ONLY:**

Is there documentation of height increase by at least 2cm/yr over the previous year of TX?

Current height: _____ Date obtained: _____

Is there documentation showing expected adult height not attained? ☐ Yes ☐ No	Is there documentation of expected adult height goal (genetic potential)? ☐ Yes	☐ No

☐ **Noonan Syndrome**

Is the member a male with bone age <16 years? ☐ Yes ☐ No ☐ N/A	Is the member a female with bone age <14 years? ☐Yes	☐ No	☐ N/A	
Height is below the 5th percentile on growth charts for age and gender?		☐Yes	☐No	

Current Height: _____ Date obtained: _____

☐ **Renewal Request ONLY:**

Is there documentation of height increase by at least 2cm/yr over the previous year of TX?

Current height: _____ Date obtained: _____

Is there documentation showing expected adult height not attained? ☐ Yes ☐ No	Is there documentation of expected adult height goal (genetic potential)? ☐ Yes	☐ No

☐ **Short Stature with SHOX Deficiency**

Is the diagnosis confirmed by genetic testing?		☐ Yes	☐ No	
Is the member a male with bone age < 16 years? ☐ Yes ☐ No ☐ N/A	Is the member a female with bone age <14 years? ☐Yes	☐ No	☐ N/A	

Current Height: _____ Date obtained: _____

☐ **Renewal Request ONLY:**

Is there documentation of height increase by at least 2cm/yr over the previous year of TX?	☐ Yes	☐ No

Current height: _____ Date obtained: _____					
Is there documentation showing expected adult height not attained?	☐ Yes	☐ No	Is there documentation of expected adult height goal (genetic potential)?	☐ Yes	☐ No
☐ **Growth Failure with Chronic Renal Insufficiency**					
Current Height: _____ Date obtained: _____					
Is the member a male with bone age <16 years?	☐ Yes	☐ No	☐ N/A		
Is the member a female with bone age <14 years?	☐Yes	☐ No	☐ N/A		
☐ **Renewal Request ONLY:**					
Is there documentation of height increase by at least 2cm/yr over the previous year of TX? Current height: _____ Date obtained: _____					
Is there documentation showing expected adult height not attained?	☐ Yes	☐ No	Is there documentation of expected adult height goal (genetic potential)?	☐ Yes	☐ No
☐ **Growth Failure in Children Small for Gestational Age**					
Current Height: _____ Date obtained: _____					
Diagnosis of small for gestational age (SGA) based on demonstration of catch-up growth failure in the first 24 months of life using a 0-36-month growth chart?				☐ Yes	☐ No
Is member below the 3rd percentile for gestational age (>2 standard deviations below population mean) for birth weight AND length?	☐ Yes	☐ No	Is there documentation that height remains equal to OR below 3rd percentile (≥ 2 standard deviations below population mean)?	☐ Yes	☐ No
☐ **Renewal Request ONLY:**					
Is there documentation of height increase by at least 2cm/yr over the previous year of TX? Current height: _____ Date obtained: _____				☐ Yes	☐ No
Is there documentation showing expected adult height not attained?	☐ Yes	☐ No	Is there documentation of expected adult height goal (genetic potential)?	☐ Yes	☐ No
☐ **Transition Phase Adolescent Members**					
Does the dose exceed MAX limit of 0.3mg/kg/wk?				☐ Yes	☐ No
Is there documentation that member attained expected adult height?	☐ Yes	☐ No	Is there documentation of bone radiograph showing closed epiphyses?	☐ Yes	☐ No
Member is at high risk of GH deficiency due to childhood-onset from ONE of the following:	☐ Embryopathic / congenital defects ☐ Irreversible structural hypothalamic-pituitary disease	☐ Genetic mutations ☐ Panhypopituitarism	At least 3 deficiencies of the following anterior pituitary hormones: ☐ FSH / LH ☐ TSH ☐ ACTH ☐ Prolactin		
Is IGF-1/Somatomedin-C level below age AND gender adjusted normal range as provided by physician's lab?	☐ Yes	☐ No	Does member have a low IGF-1/Somatomedin C level?	☐ Yes	☐ No
☐ Member has stopped GH therapy for at least ONE month AND undergone ONE provocative GH stim test confirming transition phase GH deficiency AND ONE of the following peak values:	Insulin Tolerance Test: ☐ ≤5 ng/ml	Glucagon: ☐ ≤3 ng/mL	Arginine: ☐ ≤0.4 ng/mL		
	Arginine + GHRH: ☐ ≤11 ng/mL if BMI is < 25 kg/m2 ☐ ≤8 ng/mL if BMI ≥25 and <30 kg/m2 ☐ ≤4 ng/mL if BMI ≥30 kg/m2				
Is the member at low risk of severe GH deficiency (due to isolated and/or idiopathic GH deficiency)?	☐ Yes	☐ No	Has the member discontinued GH therapy for at least 1 month?	☐ Yes	☐ No
Has the member undergone ONE of the following GH stimulation tests after D/C of therapy for at least 1 month?	☐ ITT	☐ GHRH & ARG	☐ ARG	☐ Glucagon	
Is ITT ≤5mcg/L? ☐ Yes ☐ No	Is GHRH and ARG ≤11 micg/L if BMI <25 KG/M2?	☐ Yes ☐ No			
	Is GHRH and ARG ≤8 mcg/L if BMI ≥25 and <30 kg/m2?	☐ Yes ☐ No			
	Is GHRH and ARG ≤4 mcg/L if BMI ≥30 kg/m2?	☐ Yes ☐ No			
Is glucagon ≤3 mcg/L?	☐ Yes ☐ No				
Is ARG ≤0.4mcg/L?	☐ Yes ☐ No				
☐ **Renewal Request ONLY: Is**					
Is there documentation supporting positive response to therapy (Increase in total lean body mass, increased exercise capacity OR increased IGF-1 and IGFBP-3 levels)?				☐Yes	☐No

Request does not exceed a MAX supply limit of 0.3mg/kg/wk?			☐ Yes		☐ No		
☐ **Adult Growth Hormone Deficiency**							
Is there a diagnosis of childhood-onset GHD?		☐Yes	☐No	Is there a diagnosis of adult-onset GHD?		☐Yes	☐No
Is there documentation supporting hormone deficiency is due to hypothalamic-pituitary disease from organic or known causes?		☐Yes	☐No	Was there 1 GH stim test confirming adult GH deficiency (insulin tolerance test, arginine+GHRH, glucagon, arginine)?		☐Yes	☐No
Member has ONE of the following peak value tests:	Insulin tolerance test: ☐ ≤5 ng/ml	Arginine+GHRH: ☐ ≤11 ng/mL if BMI is < 25 kg/m2 ☐ ≤8 ng/mL if BMI ≥25 and <30 kg/m2 ☐ ≤4 ng/mL if BMI ≥30 kg/m2		Glucagon: ☐ ≤3 ng/mL		Arginine: ☐ ≤0.4 ng/mL	
Is there deficiency of at least 3 anterior pituitary hormones (FSH/LH, TSH, ACTH, Prolactin)?		☐Yes	☐No	Is IGF-1/Somatomedin-C level is below age AND gender adjusted normal range as provided by physician's lab?		☐Yes	☐No
Diagnosis of panhypopituitarism?		☐Yes	☐No	Member has other diagnosis and will not use growth hormone in COMBO with Aromatase inhibitors or Androgens?		☐Yes	☐No
Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week?		☐ Yes	☐ No	Prescribed by an Endocrinologist?		☐ Yes	☐ No
☐ **Renewal Request ONLY:**							
Documentation of IGF-1/Somatomedin-C level within the past 12 months?						☐Yes	☐No
Diagnosis of panhypopituitarism?		☐Yes	☐No	Member has other diagnosis and will not use growth hormone in COMBO with Aromatase inhibitors or Androgens?		☐Yes	☐No
Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week?		☐ Yes	☐ No	Prescribed by an Endocrinologist?		☐ Yes	☐ No
☐ **HIV-Associated or Wasting Syndrome or Cachexia**							
Has there been unintentional weight loss of greater than 10% over the last 12 months?						☐Yes	☐No
Has there been unintentional weight loss of >7% over the last 6 months?		☐Yes	☐No	Has there been a loss of 5% BCM within 6 months?		☐ Yes	☐ No
Is BMI <20 kg/m2?		☐Yes	☐No	Is the member male with BCM<35% of total body weight and BMI <27 kg/m2?		☐ Yes	☐ No
Is the member a female with BCM < 23% of total body weight and BMI <27 kg/m2?		☐Yes	☐No	Was a nutritional evaluation completed since the onset of wasting first occurred?		☐ Yes	☐ No
Was there weight loss as a result of other underlying treatable conditions?		☐Yes	☐No	Was the anti-retroviral therapy optimized to decrease the viral load?		☐ Yes	☐ No
☐ **Renewal Request ONLY:**							
Is there evidence of positive response to therapy, such as ≥2% increase in body weight and/or BCM?		☐Yes	☐No	Was any of the targets or goals, such as weight, BCM, BMI achieved?		☐ Yes	☐ No
☐ **Short Bowel Syndrome**							
Is member currently receiving specialized nutrition support (IV parenteral nutrition, fluid AND micronutrient supplements)?		☐Yes	☐No	Was 4 weeks of treatment with Zorbtive previously received?		☐ Yes	☐ No
☐ **Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion**							
current height: _____ current date: _____							
Is the height standard deviation score ≤-3.0?						☐ Yes	☐ No
Is the basal IGF-1 standard deviation score ≤ -3.0		☐Yes	☐No	Is there normal or elevated growth hormone levels?		☐ Yes	☐ No
Is there documentation of open epiphyses on last bone radiograph?		☐Yes	☐No	Will member be treated with concurrent growth hormone therapy?		☐ Yes	☐ No
Is there a diagnosis of growth hormone gene deletion AND member developed neutralizing antibodies to growth hormone?						☐Yes	☐No
☐ **Renewal Request ONLY:**							
Submission of documentation of height increase of at least 2cm/yr current height: _____ current date: _____						☐ Yes	☐ No
Is there documentation showing expected adult height not attained?		☐ Yes	☐ No	Is there documentation of expected adult height goal (genetic potential)?		☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.
Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.