REALRx

PRIOR AUTHORIZATION REQUEST FORM

GROWTH HORMONE-CHILD

Genotropin®, Humatrope®, Norditropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Zomacton®, Zorbtive®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Norditropin® (somatropin), ☐ Nutropin AQ® (somatropin), ☐ Omnitrope® (somatropin)
Non-Formulary: ☐ Genotropin® (somatropin), ☐ Humatrope® (somatropin), ☐ Saizen® (somatropin), ☐ Serostim® (somatropin), ☐ Zomacton® (somatropin), ☐ Zorbtive® (somatropin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
GROWTH HORMONE DEFICIENCY (GHD)			
1. Does the member have the diagnosis of GHD in children?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Has the member had TWO separate growth hormone stimulation tests with levels less than 10ng/mL? • One GH stimulation test below 10 ng/ml (microgram/L) is sufficient for children with defined central nervous system (CNS) pathology, history of irradiation, or genetic conditions associated with GHD.	☐	☐	**Please provide documentation**
4. Has the member had ONE growth hormone stimulation test with peak level less than 15 ng/mL, and ONE IGF-I (insulin-like growth factor) and IGF-BP3 (insulin-like growth factor binding protein 3) level below normal for the member's bone age and gender?	☐	☐	**Please provide documentation**

5. Does the member have two or more other pituitary hormone deficiencies in addition to GHD? • GH stimulation tests, IGF-1 or IGF-BP3 levels are not needed if multiple pituitary hormone deficiencies exist.	☐	☐	**Please provide documentation**
6. Does the member have congenital GHD? • GH stimulation tests, IGF-1 or IGF-BP3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist.	☐	☐	**Please provide documentation**
7. Does the member have documentation of short stature/growth failure?	☐	☐	**Please provide documentation**
8. Is the member height below the 3rd percentile for the member's age and gender?	☐	☐	**Please provide documentation**
9. Does the member have an untreated growth velocity below the 25th percentile AND a height below the 5th percentile for the members age and gender?	☐	☐	**Please provide documentation**
10. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
PRADER-WILLI SYNDROME (PWS)			
1. Does the member have the diagnosis of PWS?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Has the diagnosis of PWS been confirmed with genetic testing?	☐	☐	**Please provide documentation**
4. Is the member severely obese, have a history of upper airway obstruction or sleep apnea, or have a severe respiratory impairment?	☐	☐	**Please provide documentation**
SMALL GESTATIONAL AGE			
1. Is the request for growth failure in children who fail to demonstrate catch-up growth by age 2 to 4 years?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Does documentation show that the member was born small for gestational age, defined as a birth weight and/or length of 2 or more standard deviations below the mean?	☐	☐	**Please provide documentation**
4. Does documentation show short stature/growth failure by 2 years of age when height is 2 or more standard deviations below the mean for member's age and gender	☐	☐	**Please provide documentation**
5. Have other causes for short stature such as growth inhibiting medication, endocrine disorders, and emotional deprivation or syndromes been ruled out?	☐	☐	
6. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
7. Is the member 2 years of age or older?	☐	☐	
TURNER'S OR NOONAN'S SYNDROME			
1. Is the request for growth failure associated with Turner's or Noonan's Syndrome?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
4. Does documentation show subnormal growth rate when height is below the 10th percentile for the member's age and gender?	☐	☐	**Please provide documentation**
SHORT STATURE HOMEOBOX-CONTAINING GENE (SHOX) DEFICIENCY			
1. Is the request for short stature or growth failure in children with short stature homeobox-containing gene (SHOX) deficiency?	☐	☐	

2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Does documentation show subnormal growth rate when height is at least 2 standard deviations below the normal mean for member's age and gender?	☐	☐	**Please provide documentation**
4. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
CHRONIC RENAL INSUFFICIENCY			
1. Is the request for growth failure associated with chronic renal insufficiency?	☐	☐	
2. Is the requesting provider a pediatric nephrologist?	☐	☐	
3. Does documentation show subnormal growth rate when height is below the 5th percentile and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile for member's age and gender?	☐	☐	**Please provide documentation**
4. Does the member require weekly dialysis or have a glomerular filtration rate (GFR) <75 ml/min/1.73 m^2?	☐	☐	**Please provide documentation**
5. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
PEDIATRIC BURNS			
1. Is the request for a pediatric member with burns ≥ 40% of the total body surface area?	☐	☐	**Please provide documentation**
2. Is the requesting provider a trauma/burn surgeon?	☐	☐	
NON-GROWTH HORMONE DEFICIENT SHORT STATURE (IDIOPATHIC SHORT STATURE)			
1. Is the pediatric member 5 years of age or older?	☐	☐	
2. Does documentation show pediatric member's height is less than 1.2 percentile or a standard deviation score (SDS) < -2.25 for pediatric member's age and gender?	☐	☐	**Please provide documentation**
3. Does documentation show that the member has a growth rate of < 4 cm per year OR growth (height) velocity is < 10th percentile for the member's age and gender based on at least 6 months of growth data?	☐	☐	**Please provide documentation**
4. Is the member's predicted adult height < 160 cm (63 inches) in males or < 150 cm (59 inches) in females) without growth hormone therapy?	☐	☐	**Please provide documentation**
5. Are the epiphyses open?	☐	☐	
6. Does the member have constitutional delay of growth and puberty (CDGP)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy? **Note: For pediatric burns a maximum of 12 months of therapy may be allowed.**	☐	☐	
2. Has the member's growth velocity been ≥2.5 cm/year?	☐	☐	**Please provide documentation**
3. Is the member's bone age ≤16 in males or ≤14 in females?	☐	☐	**Please provide documentation**
4. For chronic renal insufficiency, does the member require weekly dialysis or have a glomerular filtration rate (GFR) <75 mL/min/1.73 m^2?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-028
Origination Date: 05/21/2016
Reviewed/Revised Date: 01/17/2024
Next Review Date: 01/17/2025
Current Effective Date: 02/01/2024