CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Growth Hormone – Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 800-237-2767.

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

Norditropin® and Humatrope® are the preferred products for your patient's health plan.

1. What drug is being prescribed?
   - ☐ Humatrope® ***(preferred)*** ☐ Norditropin® ***(preferred)*** ☐ Serostim® ☐ Zorbtive®
   - ☐ Genotropin® ☐ Nutropin AQ® ☐ Nutropin® ☐ Omnitrope®
   - ☐ Saizen® ☐ Tev-Tropin® ☐ Other _____

2. What is the diagnosis?
   - ☐ Pediatric growth hormone deficiency (idiopathic or organic)
   - ☐ Adult growth hormone deficiency
   - ☐ Turner syndrome (TS)
   - ☐ Noonan syndrome (NS)
   - ☐ Small for gestational age (SGA)
   - ☐ Prader-Willi syndrome (PWS)
   - ☐ Chronic kidney disease (CKD)
   - ☐ SHOX deficiency (SHOXD)
   - ☐ HIV-associated wasting
   - ☐ Short bowel syndrome (SBS)
   - ☐ Treatment of extensive burns
   - ☐ Idiopathic short stature (ISS)
   - ☐ Neurosecretory growth hormone deficiency
   - ☐ Other _____

3. What is the ICD code? _____

4. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #7

5. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

6. Is the medication effective in treating the member's condition? ☐ Yes ☐ No
   Continue to #7 and complete this form in its entirety.

7. Norditropin® and Humatrope® are the preferred products. Is the physician willing to switch to either of the preferred products (Norditropin® or Humatrope®) if it's not already being prescribed? ***If yes, indicate below and fax a new prescription to 800-323-2445 and skip to next section.***
   ☐ Yes, Norditropin® ☐ Yes, Humatrope® ☐ No

8. Has the patient had an inadequate treatment response to a previous trial of Humatrope® AND Norditropin®?
   If yes, skip to next section. ☐ Yes ☐ No

9. Does the patient have a documented contraindication to Humatrope® OR Norditropin® or any of its components?
   If yes, skip to next section. ☐ Yes ☐ No

10. Is the patient intolerant to or had a confirmed adverse event with Humatrope® AND Norditropin®?
    If yes, skip to next section. ☐ Yes ☐ No

11. Does the patient have active malignancy or history of malignancy within the past 12 months? □ Yes □ No

12. Is the GH therapy being prescribed by or in consultation with one of the following specialists?
□ Endocrinologist □ Geneticist □ Pediatric nephrologist
□ Nutritional support specialist □ Gastroenterologist □ Infectious disease specialist
□ Other _____

Complete the appropriate section: Pediatric Disorders*, Adult GHD, SBS or HIV-Associated Wasting
****In addition, complete the sub-sections based on the actual diagnosis (if applicable)***

SECTION A: Pediatric Disorders

13. Document patient's pretreatment height and age:
a) Height: _____ cm Age: _____ years, _____ months Date: _____
b) Height: _____ cm Age: _____ years, _____ months Date: _____
c) Height: _____ cm Age: _____ years, _____ months Date: _____

14. Has patient had any **pretreatment** pharmacologic provocative tests? □ Yes, ***how many?*** _____ □ No
Document the provocative test results including peak level.
□ Agent: _____ Peak Level: _____ ng/mL Date: _____
□ Agent: _____ Peak Level: _____ ng/mL Date: _____

15. What is the pretreatment 1-year height velocity? _____ cm/year

16. Does the patient have a pretreatment slow growth velocity? □ Yes □ No

17. Are epiphyses still open? □ Yes □ No □ No X-ray not available

18. Is the patient post kidney transplant? □ Yes □ No

19. Document patient's current: Height: _____ cm Age: _____ years, _____ months

20. Is the patient currently on therapy?
□ Yes, document therapy start date: _____ □ No If No, skip to appropriate sub-section, if applicable

21. Is the patient growing more than 2 cm/year? □ Yes □ No
If No, document clinical reason for the lack of efficacy: _____

I. Pediatric GHD (includes panhypopituitarism)

22. Is the patient a neonate or was the patient diagnosed with GH deficiency as a neonate?
If Yes, date of diagnosis: _____ □ Yes □ No If No, skip to #24

23. Are medical records available to support the diagnosis of neonatal GH deficiency such as documented hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiencies, MRI results, or chart notes? □ Yes □ No Action Required: Attach appropriate medical records.

24. Does patient have a pituitary or central nervous system (CNS) disorder?
Indicate below or mark "None of the above"
□ Known mutation in GH-releasing hormone receptor, GH gene, GH receptor, or pituitary transcription factors
□ Optic nerve hypoplasia/septo-optic dysplasia
□ Agenesis of corpus callosum
□ CNS tumor/neoplasm (e.g., craniopharyngioma, glioma, pituitary adenoma)
□ Empty sella syndrome □ Cyst (Rathke cleft cyst or arachnoid cleft cyst)
□ Ectopic posterior pituitary □ Radiation
□ Pituitary aplasia/hypoplasia □ Chemotherapy
□ Pituitary stalk defect □ CNS infection
□ Anencephaly or prosencephaly □ Inflammatory lesion (e.g., autoimmune hypophysitis)
□ Other mid-line defect □ Infiltrative lesion (e.g., sarcoidosis, histiocytosis)
□ Vascular malformation □ Head trauma/traumatic brain injury

□ Surgery □ Aneurysmal subarachnoid hemorrhage
□ Other _____
□ None of the above

25. Does the patient have a pretreatment IGF-1 level greater than 2 SD below the mean? □ Yes □ No
Document patient's pretreatment IGF-1 level: _____ Range: _____

II. Turner Syndrome (TS)

26. Is the diagnosis confirmed by karyotyping? □ Yes □ No
If Yes, document and attach karyotype study results: _____

III. Prader-Willi Syndrome (PWS)

27. Was the diagnosis of Prader-Willi syndrome confirmed by one of the following genetic tests?
Indicate below and attach genetic test results or mark "None of the above"
□ Deletion in 15q11.2-q13 region
□ Imprinting defects/translocations involving chromosome 15
□ Maternal, uniparental disomy in chromosome 15
□ None of the above

28. If currently on therapy, has body composition and psychomotor functions improved?
□ Yes □ No □ N/A, not currently on therapy (no further questions)

29. Is the IGF-1 level elevated for age and gender? □ Yes □ No
Document patient's current IGF1- level: _____ Range: _____

IV. Small for Gestational Age (SGA)

30. What was the patient's gestational age at birth? _____ weeks _____ days

31. What was the patient's birth weight? _____ grams AND birth length? _____ cm

32. Did patient fail to manifest catch-up growth by age two as demonstrated by pretreatment height greater than 2 SD below the mean for age and gender? □ Yes □ No

V. SHOX Deficiency

33. Has the diagnosis of SHOX deficiency been confirmed by molecular or genetic analyses? □ Yes □ No
If Yes, document and attach molecular/ genetic test results: _____

VI. Idiopathic Short Stature (ISS)

34. What is the patient's pretreatment predicted adult height? _____ feet, _____ inches

SECTION B: Adult GHD

35. Has patient had any pretreatment pharmacologic provocative tests? □ Yes, How many? _____ □ No
Document the provocative test results including peak level and if two or more tests were done, skip to #41
□ Agent: _____ Peak Level: _____ ng/mL Date: _____
□ Agent: _____ Peak Level: _____ ng/mL Date: _____

36. Does the patient have a structural abnormality of the hypothalamus or pituitary gland?
Indicate below or mark "None of the above"
□ Optic nerve hypoplasia/septo-optic dysplasia
□ Agenesis of corpus callosum
□ CNS tumor/neoplasm (e.g., craniopharyngioma, glioma, pituitary adenoma)
□ Empty sella syndrome
□ Cyst (Rathke cleft cyst or arachnoid cleft cyst)
□ Ectopic posterior pituitary □ Radiation
□ Pituitary aplasia/hypoplasia □ Chemotherapy
□ Pituitary stalk defect □ CNS infection
□ Anencephaly or prosencephaly □ Inflammatory lesion (e.g., autoimmune hypophysitis)

□ Other mid-line defect
□ Vascular malformation
□ Surgery
□ Other _____
□ None of the above
□ Infiltrative lesion (e.g., sarcoidosis, histiocytosis)
□ Head trauma/traumatic brain injury
□ Aneurysmal subarachnoid hemorrhage

37. Does the patient have deficiencies of greater than or equal to 3 pituitary hormones?
Indicate ALL below or mark "None of the above"
□ Adrenocorticotropic hormone (ACTH)
□ Antidiuretic hormone (ADH)
□ Follicle stimulating hormone (FSH)
□ Luteinizing hormone (LH)
□ Oxytocin
□ Prolactin
□ Thyroid stimulating hormone (TSH)
□ None of the above

38. Did the patient have childhood-onset GHD? □ Yes □ No If No, skip to #40

39. Does the patient have a congenital abnormality of the hypothalamus or pituitary gland?
Indicate below or mark "None of the above"
□ Known mutations in GHRH receptor, GH gene, GH receptor, or pituitary transcription factors
□ Optic nerve hypoplasia/septo-optic dysplasia
□ Agenesis of corpus callosum
□ Empty sella syndrome
□ Ectopic posterior pituitary
□ Pituitary aplasia/hypoplasia
□ Pituitary aplasia/hypoplasia
□ Anencephaly or prosencephaly
□ Other mid-line defect
□ Vascular malformation
□ Other _____
□ None of the above

40. Does the patient have a low pretreatment IGF-1 level for age and gender? □ Yes □ No
Document patient's pretreatment IGF-1 level: _____ Range: _____

41. Is the patient currently on GH therapy?
□ Yes, document therapy start date: _____ □ No If No, no further questions.

42. Is the IGF-1 level normal for age and gender? □ Yes □ No
Document patient's current IGF-1 level: _____ Range: _____

SECTION C: Short Bowel Syndrome (SBS)

43. Will somatropin be used in conjunction with optimal management of SBS? □ Yes □ No

44. How long has the patient received GH therapy (lifetime)? _____ weeks

SECTION D: HIV-Related Wasting

45. Has the patient tried and had a suboptimal response to alternative therapies?
If Yes, document alternative therapies and skip to #47
□ Marinol (dronabinol) □ Megace (megesrol) □ Cyproheptadine □ Testosterone therapy if hypogonadal
□ None of the above □ Other _____

46. Did the patient have contraindication or intolerance to alternative therapies? □ Yes □ No

47. Is the patient on anti-retroviral therapy? □ Yes □ No

48. Document the following:
Pretreatment : Height: _____ cm Weight: _____ lbs / kg BMI: _____ kg/m2
Current: Height: _____ cm Weight: _____ lbs / kg BMI: _____ kg/m2

49. Is the patient currently on GH therapy?
□ Yes, document therapy start date: _____ □ No If No, skip to #54

50. Did the patient's BMI improve or stabilize in response to GH therapy? ☐ Yes ☐ No

51. Prior to initiating GH therapy, did the patient experience unintentional weight loss of greater than 5% baseline body weight in the previous 6 months? ☐ Yes ☐ No

****Attach most recent clinical notes or supporting documentation****

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**