South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Growth Hormones Prior Authorization Request Form (Page 1 of 3)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the requested medication below:

Preferred Drugs:

- ❑ Genotropin
- ❑ Norditropin

Select the requested medication below:

Non-Preferred:

- ❑ Humatrope
- ❑ Nutropin AQ
- ❑ Omnitrope
- ❑ Ngenla
- ❑ Skytrofa
- ❑ Sogroya
- ❑ Saizen
- ❑ Zomacton

Select the diagnosis below:

For Pediatric Patients (less than 18 years of age):

- ❑ Growth hormone deficiency in children
- ❑ Growth failure due to chronic renal insufficiency
- ❑ Growth failure due to panhypopituitarism
- ❑ Growth failure due to Prader-Willi syndrome
- ❑ Idiopathic short stature in children
- ❑ Noonan syndrome
- ❑ Short stature homeobox containing gene (SHOX) deficiency
- ❑ Small for gestational age
- ❑ Turner's syndrome

Select the diagnosis below:

For Adults (18 years of age or older):

- ❑ Growth hormone deficiency in adults
- ❑ Panhypopituitarism
- ❑ Prader-Willi syndrome

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Contraindications/Exclusions:

Does the patient have acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma, or acute respiratory failure? ❑ **Yes** ❑ **No**

Does the patient have active malignancy? ❑ **Yes** ❑ **No**

Does the patient have active proliferative or severe non-proliferative diabetic retinopathy? ❑ **Yes** ❑ **No**

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Growth Hormones Prior Authorization Request Form (Page 2 of 3)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For Pediatric Patients (less than 18 years of age):

Is the requested medication prescribed by or in consultation with a pediatric endocrinologist? ❑ **Yes** ❑ **No**

Are the patient's epiphyses open? ❑ **Yes** ❑ **No**

Has the patient been screened for intracranial malignancy or tumor? ❑ **Yes** ❑ **No**

For growth hormone deficiency in children, also answer the following:

Has growth hormone deficiency been confirmed with provocative test and/or IGF-1 levels? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to two (2) pharmacological growth hormone stimulation tests* with peak level below 10 ng/mL? ❑ **Yes** ❑ **No**

Has the patient had an inadequate response to at least one (1) pharmacological growth hormone stimulation test* with peak level below 10 ng/mL for a patient with defined CNS pathology, multiple pituitary hormone deficiencies, history of irradiation, or proven genetic cause? ❑ **Yes** ❑ **No**

**Please note: acceptable tests include: arginine, clonidine, glucagon, insulin, and levodopa*

Is the patient's height more than 3 standard deviations (SDs) below the mean for same age and gender? ❑ **Yes** ❑ **No**

Is the patient's height more than 2 SDs below the mean for same age and gender AND the patient has decreased growth velocity more than 1 SD below the mean for the same age and gender? ❑ **Yes** ❑ **No**

Is the patient's growth velocity measured 2 SDs below the mean over one year or 1.5 SDs below the mean sustained over 2 years for the same age and gender? ❑ **Yes** ❑ **No**

Have other causes of growth failure been ruled out (e.g., hypothyroidism, chronic systemic disease, skeletal disorders, malnutrition)? ❑ **Yes** ❑ **No**

For growth failure due to chronic renal insufficiency, also answer the following:

Has the patient's nutritional status been optimized and metabolic abnormalities been corrected? ❑ **Yes** ❑ **No**

Has the patient had a kidney transplant? ❑ **Yes** ❑ **No**

Is the patient's height less than the 3rd percentile? ❑ **Yes** ❑ **No**

Is the patient's growth velocity measured over 1 year > 2 standard deviations below the mean for same age and gender? ❑ **Yes** ❑ **No**

For growth failure due to panhypopituitarism or Prader-Willi syndrome, also answer the following:

Has the patient's diagnosis of panhypopituitarism or Prader-Willi syndrome been confirmed by appropriate genetic testing? ❑ **Yes** ❑ **No**

Is the diagnosis of panhypopituitarism caused by craniopharyngioma surgery? ❑ **Yes** ❑ **No**

Does the patient have severe obesity, history of upper airway obstruction or sleep apnea, or severe respiratory impairment? ❑ **Yes** ❑ **No**

Is the patient's height more than 2 standard deviations below the mean for same age and gender? ❑ **Yes** ❑ **No**

For idiopathic short stature, also answer the following:

Is the patient's height more than 2.25 standard deviations below the mean? ❑ **Yes** ❑ **No**

Is the patient's predicted height less than or equal to 65 inches for male or less than or equal to 60 inches for females? ❑ **Yes** ❑ **No**

For short stature homeobox-containing gene (SHOX) deficiency or Noonan syndrome, also answer the following:

Is the patient's height more than 3 standard deviations (SDs) below the mean for same age and gender? ❑ **Yes** ❑ **No**

Is the patient's height more than 2 SDs below the mean for same age and gender AND the patient has decreased growth velocity more than 1 SD below the mean for the same age and gender? ❑ **Yes** ❑ **No**

Is the patient's growth velocity measured 2 SDs below the mean over one year or 1.5 SDs below the mean sustained over 2 years for the same age and gender? ❑ **Yes** ❑ **No**

For small for gestational age (SGA), also answer the following:

Did the patient have post-natal growth failure at one year? ❑ **Yes** ❑ **No**

Is the patient below the 5th percentile for height? ❑ **Yes** ❑ **No**

Was the patient's birth weight or length at least 2 standard deviations below the mean for gestational age? ❑ **Yes** ❑ **No**

For Turner's syndrome, also answer the following:

Has the patient's diagnosis of Turner's syndrome been confirmed by chromosome analysis? ❑ **Yes** ❑ **No**

Is the patient's height less than the 5th percentile for same age and gender? ❑ **Yes** ❑ **No**

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Growth Hormones Prior Authorization Request Form (Page 3 of 3)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

For Adult Patients (18 years of age or older):

Is the requested medication prescribed by or in consultation with an endocrinologist? ❑ **Yes** ❑ **No**

For growth hormone deficiency in adults, also answer the following:

Has growth hormone deficiency been confirmed with two provocative tests and IGF-1 levels? ❑ **Yes** ❑ **No**

Has the patient been screened for intracranial malignancy or tumor? ❑ **Yes** ❑ **No**

Non-preferred drug request:

If a request for a non-preferred agent is medically necessary or required for a particular member, prescriber must provide a brief summary for use of the non-preferred agent over a preferred alternative

_____

_____

_____

_____

_____

_____

Nutropin and Nutropin AQ are non-preferred unless patient has a diagnosis of growth failure associated with chronic renal insufficiency.
Humatrope and Zomacton are non-preferred unless member has a diagnosis of SHOX deficiency

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**