UnitedHealthcare Community Plan

Growth Hormone - Pennsylvania
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 may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Clinical and Drug Specific Information

ALL REQUESTS	
	Document the patient's weight: _____ lbs/kg
□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ AIDS related cachexia □ Growth hormone deficiency (for patients 18 years of age and older or at any age with closed epiphyses) □ Neonate growth hormone deficiency □ Pediatric growth hormone deficiency □ Short bowel syndrome
□ Yes □ No	**Is the requested medication prescribed by an appropriate specialist (e.g., neonatologist [in the neonatal period], endocrinologist, gastroenterologist, or nephrologist)?**
□ Yes □ No	**Does the patient have a contraindication to the prescribed medication?**
□ Yes □ No	**Does the patient have a history of therapeutic failure of the preferred growth hormones approved or medically accepted for the patient's diagnosis?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
AIDS RELATED CACHEXIA	
	Document the patient's body mass index (BMI): _____
□ Yes □ No	**Does the patient have a diagnosis of wasting syndrome?**
□ Yes □ No □ Not applicable	**If yes to the above question, is the wasting syndrome NOT attributable to other causes, such as depression, Mycobacterium avium complex infection, chronic infectious diarrhea, or malignancy (exception: Kaposi's sarcoma limited to the skin or mucous membranes)?**
□ Yes □ No	**Does the patient have an unintentional or unexplained weight loss defined by any of the following?** *(If yes, check which applies)* □ Weight loss of greater than or equal to 10 percent from baseline premorbid weight □ BMI less than 20 in the absence of a concurrent illness or medical condition other than HIV infection that would explain these findings
□ Yes □ No	**Despite a comprehensive AIDS treatment program that includes antiretrovirals, does the patient have a history of inadequate response or intolerance to any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* □ Nutritional supplements that increase caloric and protein intake □ Steroid hormones such as megestrol
GROWTH HORMONE DEFICIENCY (for patients 18 years of age and older or at any age with closed epiphyses)	
□ Yes □ No	**Does the patient have a documented history of adult growth hormone deficiency as a result of any of the following?** *(If yes, check which applies)* □ Childhood-onset growth hormone deficiency □ Pituitary or hypothalamic disease □ Surgery or radiation therapy □ Trauma
□ Yes □ No	**Was the diagnosis of growth hormone deficiency confirmed according to the current consensus guidelines (e.g., American Association of Clinical Endocrinologists)?**
□ Yes □ No	**Is the patient currently receiving replacement therapy for any other pituitary hormone deficiencies?**
□ Yes □ No □ Not applicable	**If yes to the above question, is the replacement therapy consistent with current medical standards of practice?**
□ Yes □ No	**For traumatic brain injury or subarachnoid hemorrhage, does the patient have documentation of results of stimulation testing obtained at least 12 months after the date of injury?**
NEONATE GROWTH HORMONE DEFICIENCY	
□ Yes □ No	**Was the diagnosis of growth hormone deficiency confirmed according to the current consensus guidelines (e.g., Pediatric Endocrine Society)?**

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PEDIATRIC GROWTH HORMONE DEFICIENCY	
□ Yes □ No	**Is the patient in a Tanner stage greater than or equal to 3?**
□ Yes □ No	**Does the patient have epiphyses that are confirmed as open?**
□ Yes □ No □ Not applicable	**For a diagnosis OTHER than Turner syndrome, Prader Willi Syndrome, or small for gestational age (SGA), has the patient had appropriate imaging (MRI or CT) of the brain with particular attention to the hypothalamic and pituitary regions to exclude the possibility of a tumor?**
□ Yes □ No	**Is the patient's growth failure due to idiopathic short stature, familial short stature, or constitutional growth delay?**
□ Yes □ No	**Have other causes of short stature been excluded?**
□ Yes □ No	**Does the patient have a diagnosis of growth hormone deficiency confirmed according to the current consensus guidelines (e.g., Pediatric Endocrine Society)?**
□ Yes □ No	**Does the patient have a diagnosis of insulin-like growth factor-1 (IGF-1) deficiency with any of the following?** *(If yes, check which applies)* □ Height greater than 2.25 standard deviations (SD) below the mean for age or greater than 2 SD below the mid-parental height percentile □ Growth velocity less than 25th percentile for bone age □ Secondary causes of IGF-1 deficiency have been excluded (i.e., under-nutrition and hepatic disease) □ History of having passed growth hormone stimulation tests
□ Yes □ No	**Does the patient have a diagnosis of chronic renal failure with any of the following?** *(If yes, check which applies)* □ Diagnosis of pediatric growth failure, defined as height greater than 2 SD below the age-related mean, due to chronic renal failure □ Has not undergone a renal transplant
□ Yes □ No	**Does the patient have a diagnosis of small for gestational age (SGA) with any of the following?** *(If yes, check which applies)* □ Patient was born SGA, defined as having weight or length at birth greater than 2 SD below the mean or weight below the 10th percentile for gestational age □ Patient failed to manifest catch-up growth by 2 years of age, defined as height/length greater than or equal to 2 SD below the mean for age and gender
□ Yes □ No	**Does the patient have a documented diagnosis of Turner syndrome, Noonan syndrome, or short stature homeobox (SHOX) syndrome with growth failure defined as height greater than 2 SD below the age-related mean?**
□ Yes □ No	**Does the patient have a documented diagnosis of Prader-Willi syndrome with any of the following?** *(If yes, check which applies)* □ Growth failure defined as height greater than 2 SD below the age-related mean □ No symptoms of sleep apnea □ History of sleep apnea or symptoms consistent with sleep apnea and has been fully evaluated and treated
CONTINUATION OF THERAPY - AIDS RELATED CACHEXIA	
□ Yes □ No	**Has the patient demonstrated either of the following since starting the requested medication?** *(If yes, check which applies)* □ Weight stabilization □ Weight increase
□ Yes □ No	**Is this request for a dose increase?**
□ Yes □ No □ Not applicable	**If yes to the above question, does the patient demonstrate compliance with the requested medication?**

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CONTINUATION OF THERAPY - GROWTH HORMONE DEFICIENCY (for patients 18 years of age and older or at any age with closed epiphyses)	
□ **Yes** □ **No**	**Has the patient experienced clinical benefit since starting the requested medication as evidenced by any of the following?** *(If yes, check which applies)* □ Increase in total lean body mass □ Increase in exercise capacity □ Improved energy level
□ **Yes** □ **No**	**Is this request for a dose increase?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above question, does the patient demonstrate compliance with the requested medication?**
CONTINUATION OF THERAPY - NEONATE GROWTH HORMONE DEFICIENCY	
□ **Yes** □ **No**	**Is this request for a dose increase?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above question, does the patient demonstrate compliance with the requested medication?**
CONTINUATION OF THERAPY - PEDIATRIC GROWTH HORMONE DEFICIENCY	
□ **Yes** □ **No**	**Is the patient in a Tanner stage greater than or equal to 3?**
□ **Yes** □ **No**	**Does the patient have epiphyses that are confirmed as open within the previous 6 months?**
□ **Yes** □ **No**	**Has the patient demonstrated a growth response greater than or equal to 4 centimeters (cm) per year?**
□ **Yes** □ **No**	**Has the patient reached expected final adult height (defined as mid-parental height)?**
□ **Yes** □ **No**	**Is this request for a dose increase?**
□ **Yes** □ **No** □ **Not applicable**	**If yes to the above question, does the patient demonstrate compliance with the requested medication?**
□ **Yes** □ **No**	**For a diagnosis of Prader-Willi syndrome, has the patient demonstrated improvement in lean-to-fat body mass OR growth velocity since starting the requested medication?**

Provider Signature: _____ **Date:** _____