United Healthcare Community Plan

24 HOURS – URGENT
Growth hormones - Texas
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.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

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: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

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

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ **Yes** □ **No**	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Chronic kidney disease (CKD) □ Growth hormone deficiency (GHD) □ Human immunodeficiency virus (HIV) with cachexia □ Idiopathic short stature (ISS) □ Noonan syndrome □ Panhypopituitarism □ Prader-Willi syndrome □ Short bowel syndrome □ Short stature homeobox (SHOX) deficiency □ Turner syndrome
□ **Yes** □ **No**	**Does the patient have a diagnosis of active malignancy in the last 180 days?**
□ **Yes** □ **No**	**Does the patient have a history of chemotherapy/radiation in the last 180 days?**
□ **Yes** □ **No**	**Does the patient have a diagnosis of active proliferative or severe non-proliferative diabetic retinopathy in the last 365 days?**
CHRONIC KIDNEY DISEASE (CKD)	
□ **Yes** □ **No**	**Does the patient have a history of a renal transplant in the last 3 years?**
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ GFR (glomerular filtration rate) less than or equal to 75 mL/min/1.73m^2 □ Patient's height > 2.25 SD (standard deviations) below the mean for age □ Patient's height > 2 SD below the mid-parental height percentile □ Patient's Z score < -1.88 □ Pre-transplant
□ **Yes** □ **No**	**If the request is for renewal, does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Patient's growth exceeds 2 cm (centimeters)/year □ Pre-transplant □ Epiphyses are open
GROWTH HORMONE DEFICIENCY (GHD)	
For patients less than or equal to 16 years of age	
□ **Yes** □ **No**	**Has the patient failed to respond [response < 10 ng/mL (nanograms/milliliter)] to at least 2 growth hormone stimulation tests?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Height > 2.25 SD (standard deviations) below the mean for age □ Height > 2 SD below the mid-parental height percentile
□ **Yes** □ **No**	**Does the patient have growth velocity < 25th percentile for bone age?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**If the request is for renewal, does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Growth exceeds 2 cm (centimeters)/year □ Epiphyses are open
For patients 17 years of age or older	
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ IGF-1 (insulin-like growth factor 1) level < 160 ng/mL □ Failure to respond to two growth hormone stimulation tests (response less than or equal to 5 ng/mL)
□ **Yes** □ **No**	**If the request is for renewal, is there documentation to support the requested diagnosis?** *DOCUMENTATION REQUIRED*

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Member First name:	**Member Last name:**	**Member DOB:**

IDIOPATHIC SHORT STATURE (ISS)	
For patients less than or equal to 16 years of age	
□ **Yes** □ **No**	**Is the patient's height > 2.25 SD (standard deviations) below the mean for age?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**Is the patient's predicted adult height < 63 inches for males or < 59 inches for females?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**If the request is for renewal, does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Patient's growth exceeds 2 cm (centimeters)/year □ Patient's growth shows an increase in height velocity of 50% □ Patient's growth shows an increase of at least 2.5 cm/year above the baseline height velocity □ Epiphyses are open
For patients 17 years of age or older	
□ **Yes** □ **No**	**Is there documentation to support the requested diagnosis?** *DOCUMENTATION REQUIRED*
□ **Yes** □ **No**	**If the request is for renewal, does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Patient's growth exceeds 2 cm/year [If patient has been treated as a pediatric patient (less than or equal to 16 years of age) and is requesting a refill] □ Bone age < 16 years □ Epiphyses are open
PANHYPOPITUITARISM	
□ **Yes** □ **No**	**Does the patient have any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ IGF-1 (insulin-like growth factor 1) level < 160 ng/mL (nanograms per milliliter) □ Failure to respond (response less than or equal to 5 ng/mL) to one growth hormone stimulation test

Provider Signature: _____ **Date:** _____