Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Growth Hormone (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Growth Hormone (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (circle)

Omnitrope vials (preferred)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Is growth hormone prescribed by a specialist based on the condition treated (e.g., endocrinologist, nephrologist)? Y N

   List specialty here: _____

   [If no, then no further questions.]

2. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If yes, skip to question 55.]

3. Does the member have a diagnosis of idiopathic short stature? Y N

[If yes, then no further questions.]

4. Is this request for an infant/child or adolescent with a diagnosis of growth hormone deficiency? Y N

   Note: If the request is for a transition phase adolescent member with closed epiphyses continuing therapy for childhood-onset growth hormone deficiency, please answer 'No.'

   [If no, skip to question 17.]

5. Is the member an infant less than 4 months of age with growth hormone deficiency? Y N

   [If yes, skip to question 13.]

6. Does the member have a history of neonatal hypoglycemia associated with pituitary disease? Y N

   [If yes, skip to question 13.]

7. Does the member have a diagnosis of panhypopituitarism? Y N

   [If yes, skip to question 13.]

8. Does the member have a history of irradiation, surgery or trauma to the hypothalamic-pituitary area? Y N

   [If yes, skip to question 13.]

9. Does the member have a defined CNS (central nervous system) pathology confirmed by MRI or CT that has also ruled out the presence of a brain tumor (e.g., craniopharyngioma)? Y N

   Note: MRI/CT should be done to exclude a brain tumor. Members with GHD have an abnormality of the pituitary gland (e.g., ectopic bright spot, empty or small sella).

   [If yes, skip to question 13.]

10. Does the member have a diagnosis of pediatric growth hormone deficiency confirmed by a height more than 2 standard deviations (SD) below mid parental height (projected height) OR more than 2.25 SD below the population mean for age and gender? Y N

    If yes, document member's height: _____

    [If yes, skip to question 13.]

11. Does the member have a diagnosis of pediatric growth hormone deficiency confirmed by a growth velocity more than 2 standard deviations (SD) below the population mean for age and gender? Y N

    If yes, document member's growth velocity: _____

    [If yes, skip to question 13.]

12. Does the member have a diagnosis of pediatric growth hormone deficiency with a delayed bone age confirmed by X-ray that shows a bone age (BA) compared to chronological age equal to or greater than 2 SD below the mean for age and gender (e.g., delayed 2 years or more compared with chronological age)? Y N

    [If no, then no further questions.]

13. Have other pituitary hormone deficiencies (e.g., hypothyroidism, chronic ischemic disease) been ruled out? Y N

    [If no, then no further questions.]

14. Did the member have a peak growth hormone level below 10 mcg/L on a fasting growth hormone stimulation test using at least one of the following provocative agents: arginine, glucagon, clonidine, insulin, levodopa, GHRH (growth hormone releasing hormone)? Y N

    Please provide peak level and agent(s) tried:
    _____

    [If yes, skip to question 40.]

15. Did the member have peak growth hormone levels below 10 mcg/L on fasting growth hormone stimulation tests using 2 of the following provocative agents: arginine, glucagon, clonidine, insulin, propranolol, levodopa? Y N

    Please provide peak level and agent(s) tried:
    _____

    [If yes, skip to question 40.]

16. Is the request for child less than 1 year of age who has an IGF-1 (insulin-like growth factor 1) or IGFBP-3 (insulin-like growth factor binding protein 3) level below the age and gender adjusted normal range as provided by the physician's lab? Y N

    Please provide level: _____

    [If yes, skip to question 40.]

[If no, then no further questions.]

17. Is this request for a child or adolescent with a diagnosis of Prader-Willi syndrome (PWS)? Y N

    [If no, skip to question 19.]

18. Has the diagnosis been confirmed by genetic testing showing a deletion in chromosomal 15q11.2-q13 region, maternal uniparental disomy in chromosome 15, imprinting defects or translocations involving chromosome 15? Y N

    [If no, then no further questions.]

    [If yes, skip to question 39.]

19. Is this request for a child or adolescent with a diagnosis of Turner Syndrome (TS, gonadal dysgenesis)? Y N

    [If no, skip to question 22.]

20. Has the diagnosis been confirmed with a karyotype showing a 45, XO genotype? Y N

    [If no, then no further questions.]

21. Is the member a female greater than 2 years of age with a bone age less than 14 years? Y N

    [If yes, skip to question 39.]

    [If no, then no further questions.]

22. Is this request for a child or adolescent with a diagnosis of Noonan Syndrome? Y N

    [If no, skip to question 24.]

23. Is the request for Norditropin? Y N

    [If yes, skip to question 38.]

    [If no, then no further questions.]

24. Is this request for a child or adolescent with a diagnosis of pediatric growth failure associated with SHOX (short stature homeobox-containing gene) deficiency? Y N

    [If no, skip to question 27.]

25. Is the request for Humatrope? Y N

    [If no, then no further questions.]

26. Has the diagnosis been confirmed by genetic testing? Y N

    [If yes, skip to question 38.]

    [If no, then no further questions.]

27. Is this request for a child or adolescent with a diagnosis of pediatric growth failure associated with chronic kidney disease (chronic renal insufficiency) (e.g., GFR below 30 ml/min)? Y N

    [If no, skip to question 33.]

28. Is the request for Nutropin? Y N

    [If no, then no further questions.]

29. Has the member undergone a kidney transplant? Y N

    [If yes, then no further questions.] Y N

30. Have metabolic abnormalities (such as malnutrition, zinc deficiency, secondary hyperparathyroidism) been corrected if they exist? Y N

    [If no, then no further questions.]

31. Does the member have a bone age compared to chronological age equal to or greater than 2 standard deviations (SD) below the mean for age and gender (e.g., delayed 2 years or more compared with chronological age)? Y N

    [If yes, skip to question 52.]

32. Is the member's growth velocity more than 2 standard deviations (SD) below the mean for age and sex? Y N

    If yes, document member's growth velocity: _____

    [If yes, skip to question 52.]

    [If no, then no further questions.]

33. Does the member have a diagnosis of small for gestational age (SGA) (fetal growth retardation)? Y N

    [If no, skip to question 41.]

34. Is the member older than 2 years of age? Y N

[If no, then no further questions.]

35. Is the request for a child who failed to catch up growth in the first 24 months of life (by 2 years of age) or with no catch up growth using a 0-36 month growth chart? Y N

    [If no, then no further questions.]

36. Is the member's height below the 3rd percentile (more than 2 standard deviations (SD) below the population mean) for age and gender? Y N

    Document height: _____

    [If no, then no further questions]

37. Was the member's birth weight and length below the 3rd percentile (more than 2 standard deviations (SD) below the population mean) for gestational age (GA)? Y N

    Document GA, birth weight and length:
    _____

    [If yes, skip to question 52.]

    [If no, then no further questions.]

38. Does the member have a bone age compared to chronological age equal to or greater than 2 standard deviations (SD) below the mean for age and gender (e.g., delayed 2 years or more compared with chronological age)? Y N

    [If yes, skip to question 40.]

39. Is the member's growth velocity more than 2 standard deviations (SD) below the mean for age and sex? Y N

    If yes, document member's growth velocity: _____

    [If no, then no further questions.]

40. Does the member have open epiphyses (confirmed open growth plates for members over 12 years of age)? Y N

    [If yes, skip to question 52.]

    [If no, then no further questions.]

41. Is the request for a transition phase adolescent member with closed epiphyses who has attained expected adult height and is continuing therapy for childhood-onset growth hormone deficiency? Y N

Note: Transition phase is defined as the period of life starting in late puberty and ending with full adult maturation (from mid to late teenage years) until 6-7 years after achievement of final height. There is no proven benefit to continuing growth hormone treatment in adulthood for childhood growth hormone treatment of conditions other than growth hormone deficiency (e.g., Turner syndrome).

[If no, skip to question 45.]

42. Is the member at high risk of growth hormone deficiency due to childhood-onset GHD from one of the following: A) Hypothalamic-pituitary structural defect or tumor, B) At least 3 deficiencies of anterior pituitary hormones (e.g., FSH/LH, TSH, ACTH, prolactin) or panhypopituitarism, OR C) a genetic cause of growth hormone deficiency? Y N

[If no, then no further questions.]

43. Does the member have an IGF-1 (insulin-like growth factor-1) level below the age and gender adjusted normal range as provided by the physician's lab? Y N

[If yes, skip to question 52.]

44. Did the member stop growth hormone therapy for at least one month and have the diagnosis of growth hormone deficiency reconfirmed by one of the following: A) One low IGF-1/IGFBP-3 and one growth hormone stim test with growth hormone peak value of less than 10 mcg/ml, or B) Two growth hormone stim tests with growth hormone peak value of less than 10 mcg/ml Y N

[If yes, skip to question 52.]

[If no, then no further questions.]

45. Does the member have a diagnosis of adult-onset growth hormone deficiency? Y N

[If yes, skip to question 47.]

46. Does the member have a diagnosis of adult growth hormone deficiency of childhood-onset? Y N

[If no, then no further questions.]

47. Is growth hormone deficiency due to hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma or subarachnoid hemorrhage)? Y N

[If no, skip to question 50.]

48. Has the member undergone one provocative GH stimulation test (e.g., ITT, arginine plus GHRH (growth hormone releasing hormone))? Y N

    [If no, skip to question 50.]

49. Did the member have one of the following peak values following the stimulation test? A) Less than or equal to 5ng/ml using insulin tolerance test (ITT), B) Less than or equal to 11 ng/ml if body mass index (BMI) is below 25 kg/m2, less than or equal to 8 ng/ml if BMI is 25 kg/m2 or higher but less than 30 kg/m2, or less than or equal to 4 ng/ml if BMI is 30 kg/m2 or higher using arginine plus GHRH, C) Less than or equal to 3 ng/ml using glucagon, D) Less than or equal to 0.4 ng/ml using arginine Y N

    Please provide peak level and testing method:

    _____

    [If yes, skip to question 52.] Y N

50. Does the member have at least 3 deficiencies of anterior pituitary hormones (e.g., FSH/LH, TSH, ACTH, prolactin) or panhypopituitarism? Y N

    [If no, then no further questions.]

51. Does the member have an IGF-1 (insulin-like growth factor-1) level below the age and gender adjusted normal range as provided by the physician's lab? Y N

    Please provide IGF-1 level and date drawn: _____

    [If no, then no further questions.]

52. Is the requested medication a formulary preferred agent? Y N

    [If yes, then no further questions]

53. Has the member had an inadequate response, intolerable side effect, or contraindication to a preferred agent? Y N

    If yes, list medication(s) tried and reason for failure or contraindication:

    _____

    [If yes, then no further questions.]

54. Is the member unable to use a vial formulation due to disability (i.e., visual/physical impairment) OR is there no preferred product appropriate for the condition being treated? Y N

    If yes, please indicate which applies to the member: _____

[No further questions.]

55. Is the reauthorization request for a child or adolescent? Y N

[If no, skip to question 63.]

56. Is the request for a transition phase adolescent member? Y N

[If yes, skip to question 63.]

57. Is the request for treatment of Prader-Willi syndrome? Y N

[If no, skip to question 59.]

58. Is the member having a positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)? Y N

[If yes, then no further questions.]

59. Is the member having a positive response to therapy as demonstrated by a height increase of at least 2.5 cm/year (post-pubertal growth rate) or 4.5 cm/year (pre-pubertal growth rate)? Y N

Please document current height and growth velocity: _____

[If no, then no further questions.]

60. Has the member achieved expected final height? Y N

[If yes, then no further questions.]

61. Are growth (epiphyseal) plates still open? Y N

[If no, then no further questions.]

62. Does the member have a bone age less than 16 years if male or less than 14 years if female? Y N

[No further questions.]

63. Is the member having a positive response to therapy (e.g., increase in total lean body mass, increased exercise capacity or increase in IGF-1 level)? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**