



Fax completed prior authorization request form to 855-247-3677 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at [www.mercycareaz.org/providers/rbha-forproviders/pharmacy](http://www.mercycareaz.org/providers/rbha-forproviders/pharmacy)

## Growth Hormone & Growth Stimulating Agents Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

**REQUIRED: Chart notes that include weight, height, growth velocity and lab values (GH levels, IGF-1 / IGFBP-3), stim test results, bone age**

Member Information							
Member Name (first & last):	Date of Birth:	Gender:		Height:			
		<input type="checkbox"/> Male	<input type="checkbox"/> Female				
Member ID:	City:	State:		Weight:			
Prescribing Provider Information							
Provider Name (first & last):	Specialty:	NPI#	DEA#				
Office Address:	City:	State:	Zip Code:				
Office Contact:	Office Phone		Office Fax:				
Dispensing Pharmacy Information							
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:				
Requested Medication Information							
<b>Preferred Agents:</b>	<input type="checkbox"/> Genotropin or Genotropin MiniQuick		<input type="checkbox"/> Norditropin FlexPro				
<b>Non-Preferred Agents:</b>	<input type="checkbox"/> Humatrope	<input type="checkbox"/> Increlex	<input type="checkbox"/> Ngenla	<input type="checkbox"/> Nutroprin AQ Nuspin	<input type="checkbox"/> Omnitrope		
	<input type="checkbox"/> Saizen	<input type="checkbox"/> Serostim	<input type="checkbox"/> Skytrofa	<input type="checkbox"/> Sogroya	<input type="checkbox"/> Zomacton		
	<input type="checkbox"/> Zorbtive	<input type="checkbox"/> Other Please Specify:					
Are there any contraindications to formulary medications? (if yes, please specify):				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one):    Yes    No			What medication(s) have been tried and failed for this diagnosis? (please specify):				
What is the diagnosis ICD-10 Code?			Diagnosis:				
Directions for Use:		Strength:		Dosage Form:			
		Quantity:	Day Supply:	Duration of Therapy/Use:			
Turn-Around Time for Review							
<input type="checkbox"/> Standard – (24 hours)	<input type="checkbox"/> <b>Urgent</b> – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.						
Signature: _____							
Clinical Information							
<input type="checkbox"/> <b>Pediatric Growth Hormone Deficiency</b>							
Current height:			Date Obtained:				
<input type="checkbox"/> Does the member have history of neonatal hypoglycemia associated with pituitary disease?				<input type="checkbox"/> Yes	<input type="checkbox"/> No		
DX is pediatric GH deficiency confirmed by ONE of the following:	<input type="checkbox"/> Projected height >2 SD below mid-parental height using age AND gender growth charts related to height						
	<input type="checkbox"/> Height is >2.25 SD below population mean using age and gender growth charts related to height						
	<input type="checkbox"/> Growth velocity is >2 SD below mean for age and gender						
	<input type="checkbox"/> Delayed skeletal maturation >2 SD below mean for age AND gender						

<input type="checkbox"/> Male with bone age <16 years?		<input type="checkbox"/> Female with bone age <14 years?					
Documentation of TWO of the following GH stimulating tests with BOTH response values <10 mcg/L?				<input type="checkbox"/> Arginine	<input type="checkbox"/> Clonidine	<input type="checkbox"/> GH releasing hormone	
				<input type="checkbox"/> Levodopa	<input type="checkbox"/> Glucagon	<input type="checkbox"/> Insulin	
Age <1 year AND IGF-1 OR IGFBP-3 is below age AND gender adjusted normal range as provided by physician's lab						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does dosing exceed MAX supply limit of 0.3 mg/kg/wk?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is staging at Tanner Stage 3 or greater AND dosing does NOT exceed MAX supply limit of 0.7 mg/kg/wk?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Documentation of height increase by at least 2cm/yr: current height _____ date obtained: _____							
Is there documentation showing expected adult height not attained?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documentation of calculated height GV over the past 12 months?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Male with bone <16 years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Female with bone age <14 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does dosing exceed a MAX supply limit of 0.3mg/kg/wk?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is staging at Tanner Stage 3 or greater AND dosing does NOT exceed MAX supply limit of 0.7mg/kg/wk?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Prader-Willi Syndrome</b>							
Current Height: _____				Date obtained: _____			
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Is there documentation of evidence of positive response to therapy (increase in total lean body mass, decrease in fat mass)?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there documentation of height increase by at least 2cm/yr over the previous year of TX? Current height: _____ Date obtained: _____							
Is there documentation showing expected adult height not attained?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Turner Syndrome</b>							
Diagnosis of pediatric growth failure associated with Turner Syndrome?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the member a female AND bone age is <14 years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Height is below the 5th percentile on growth charts for age AND gender?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Is there documentation of height increase by at least 2cm/yr over the previous year of TX? Current height: _____ Date obtained: _____							
Is there documentation showing expected adult height not attained?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Noonan Syndrome</b>							
Is the member a male with bone age <16 years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is the member a female with bone age <14 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Height is below the 5th percentile on growth charts for age and gender?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current Height: _____				Date obtained: _____			
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Is there documentation of height increase by at least 2cm/yr over the previous year of TX? Current height: _____ Date obtained: _____							
Is there documentation showing expected adult height not attained?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> <b>Short Stature with SHOX Deficiency</b>							
Is the diagnosis confirmed by genetic testing?						<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the member a male with bone age < 16 years?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is the member a female with bone age <14 years?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Current Height: _____				Date obtained: _____			
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Is there documentation of height increase by at least 2cm/yr over the previous year of TX?						<input type="checkbox"/> Yes	<input type="checkbox"/> No

Current height: _____			Date obtained: _____				
Is there documentation showing expected adult height not attained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> <b>Growth Failure with Chronic Renal Insufficiency</b>							
Current Height: _____			Date obtained: _____				
Is the member a male with bone age <16 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is the member a female with bone age <14 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Is there documentation of height increase by at least 2cm/yr over the previous year of TX?							
Current height: _____			Date obtained: _____				
Is there documentation showing expected adult height not attained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> <b>Growth Failure in Children Small for Gestational Age</b>							
Current Height: _____			Date obtained: _____				
Diagnosis of small for gestational age (SGA) based on demonstration of catch-up growth failure in the first 24 months of life using a 0-36-month growth chart?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is member below the 3rd percentile for gestational age (>2 standard deviations below population mean) for birth weight AND length?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation that height remains equal to OR below 3rd percentile ( $\geq 2$ standard deviations below population mean)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> <b>Renewal Request ONLY:</b>							
Is there documentation of height increase by at least 2cm/yr over the previous year of TX?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Current height: _____			Date obtained: _____				
Is there documentation showing expected adult height not attained?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of expected adult height goal (genetic potential)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> <b>Transition Phase Adolescent Members</b>							
Does the dose exceed MAX limit of 0.3mg/kg/wk?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there documentation that member attained expected adult height?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of bone radiograph showing closed epiphyses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Member is at high risk of GH deficiency due to childhood-onset from ONE of the following:	<input type="checkbox"/> Embryopathic / congenital defects		<input type="checkbox"/> Genetic mutations	At least 3 deficiencies of the following anterior pituitary hormones: <input type="checkbox"/> FSH / LH <input type="checkbox"/> TSH <input type="checkbox"/> ACTH <input type="checkbox"/> Prolactin			
	<input type="checkbox"/> Irreversible structural hypothalamic-pituitary disease		<input type="checkbox"/> Panhypopituitarism				
Is IGF-1/Somatomedin-C level below age AND gender adjusted normal range as provided by physician's lab?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have a low IGF-1/Somatomedin C level?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
<input type="checkbox"/> Member has stopped GH therapy for at least ONE month AND undergone ONE provocative GH stim test confirming transition phase GH deficiency AND ONE of the following peak values:			<u>Insulin Tolerance Test:</u> <input type="checkbox"/> $\leq 5$ ng/ml	<u>Glucagon:</u> <input type="checkbox"/> $\leq 3$ ng/mL	<u>Arginine:</u> <input type="checkbox"/> $\leq 0.4$ ng/mL		
			<u>Arginine + GHRH:</u> <input type="checkbox"/> $\leq 11$ ng/mL if BMI is < 25 kg/m <sup>2</sup> <input type="checkbox"/> $\leq 8$ ng/mL if BMI $\geq 25$ and <30 kg/m <sup>2</sup> <input type="checkbox"/> $\leq 4$ ng/mL if BMI $\geq 30$ kg/m <sup>2</sup>				
Is the member at low risk of severe GH deficiency (due to isolated and/or idiopathic GH deficiency)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the member discontinued GH therapy for at least 1 month?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Has the member undergone ONE of the following GH stimulation tests after D/C of therapy for at least 1 month?			<input type="checkbox"/> ITT	<input type="checkbox"/> GHRH & ARG	<input type="checkbox"/> ARG	<input type="checkbox"/> Glucagon	
Is ITT $\leq 5$ mcg/L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is GHRH and ARG $\leq 11$ mcg/L if BMI <25 KG/M <sup>2</sup> ?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Is GHRH and ARG $\leq 8$ mcg/L if BMI $\geq 25$ and <30 kg/m <sup>2</sup> ?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Is GHRH and ARG $\leq 4$ mcg/L if BMI $\geq 30$ kg/m <sup>2</sup> ?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is glucagon $\leq 3$ mcg/L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Is ARG $\leq 0.4$ mcg/L?	<input type="checkbox"/> Yes	<input type="checkbox"/> No					
<input type="checkbox"/> <b>Renewal Request ONLY: Is</b>							
Is there documentation supporting positive response to therapy (Increase in total lean body mass, increased exercise capacity OR increased IGF-1 and IGFBP-3 levels)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Request does not exceed a MAX supply limit of 0.3mg/kg/wk?		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
<b><input type="checkbox"/> Adult Growth Hormone Deficiency</b>					
Is there a diagnosis of childhood-onset GHD?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a diagnosis of adult-onset GHD?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation supporting hormone deficiency is due to hypothalamic-pituitary disease from organic or known causes?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was there 1 GH stim test confirming adult GH deficiency (insulin tolerance test, arginine+GHRH, glucagon, arginine)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Member has ONE of the following peak value tests:	Insulin tolerance test: <input type="checkbox"/> ≤5 ng/ml	Arginine+GHRH: <input type="checkbox"/> ≤11 ng/mL if BMI is < 25 kg/m2 <input type="checkbox"/> ≤8 ng/mL if BMI ≥25 and <30 kg/m2 <input type="checkbox"/> ≤4 ng/mL if BMI ≥30 kg/m2		Glucagon: <input type="checkbox"/> ≤3 ng/mL	Arginine: <input type="checkbox"/> ≤0.4 ng/mL
Is there deficiency of at least 3 anterior pituitary hormones (FSH/LH, TSH, ACTH, Prolactin)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is IGF-1/Somatomedin-C level is below age AND gender adjusted normal range as provided by physician's lab?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis of panhypopituitarism?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Member has other diagnosis and will not use growth hormone in COMBO with Aromatase inhibitors or Androgens?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Prescribed by an Endocrinologist?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><input type="checkbox"/> Renewal Request ONLY:</b>					
Documentation of IGF-1/Somatomedin-C level within the past 12 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis of panhypopituitarism?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Member has other diagnosis and will not use growth hormone in COMBO with Aromatase inhibitors or Androgens?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Prescribed by an Endocrinologist?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><input type="checkbox"/> HIV-Associated or Wasting Syndrome or Cachexia</b>					
Has there been unintentional weight loss of greater than 10% over the last 12 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has there been unintentional weight loss of >7% over the last 6 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Has there been a loss of 5% BCM within 6 months?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is BMI <20 kg/m2?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the member male with BCM<35% of total body weight and BMI <27 kg/m2?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the member a female with BCM < 23% of total body weight and BMI <27 kg/m2?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was a nutritional evaluation completed since the onset of wasting first occurred?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Was there weight loss as a result of other underlying treatable conditions?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was the anti-retroviral therapy optimized to decrease the viral load?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><input type="checkbox"/> Renewal Request ONLY:</b>					
Is there evidence of positive response to therapy, such as ≥2% increase in body weight and/or BCM?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was any of the targets or goals, such as weight, BCM, BMI achieved?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><input type="checkbox"/> Short Bowel Syndrome</b>					
Is member currently receiving specialized nutrition support (IV parenteral nutrition, fluid AND micronutrient supplements)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was 4 weeks of treatment with Zorbtive previously received?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><input type="checkbox"/> Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion</b>					
current height: _____		current date: _____			
Is the height standard deviation score ≤-3.0?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the basal IGF-1 standard deviation score ≤ -3.0		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there normal or elevated growth hormone levels?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there documentation of open epiphyses on last bone radiograph?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Will member be treated with concurrent growth hormone therapy?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there a diagnosis of growth hormone gene deletion AND member developed neutralizing antibodies to growth hormone?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b><input type="checkbox"/> Renewal Request ONLY:</b>					
Submission of documentation of height increase of at least 2cm/yr				<input type="checkbox"/> Yes <input type="checkbox"/> No	
current height: _____		current date: _____			
Is there documentation showing expected adult height not attained?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there documentation of expected adult height goal (genetic potential)?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.