UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhcprovider.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: Initial here if DAW:

Physician Signature**: By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐ Yes ☐ No

Is this medication a **New Start**? ☐ Yes ☐ No

If continuation please provide the following: Initiation Date: / / Date of Last Dose: / /

Is there documentation of positive clinical response to current therapy? ☐ Yes ☐ No

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed.**

Delivery Instructions

Note: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self-Administered ☐ LTC ☐ Physician's Office ☐

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Agents

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 contains 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:		

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

Medications	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

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Agents

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Adult growth hormone deficiency □ Growth hormone gene deletion □ Growth failure in children small for gestational age (SGA) □ Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia □ Noonan syndrome □ Pediatric growth failure associated with chronic renal insufficiency □ Other. Please specify: _____ □ Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency □ Pediatric growth hormone deficiency (GHD) □ Prader-Willi syndrome □ Severe primary IGF-1 deficiency □ Short bowel syndrome □ Transition phase adolescent patient □ Turner syndrome (Gonadal dysgenesis)
□ Yes □ No	**Does the patient have a diagnosis of panhypopituitarism?**
□ Yes □ No	**Is the requested medication prescribed by any of the following?** *(If yes, check which applies)* □ Endocrinologist □ Nephrologist
Document the patient's Tanner stage: _____	
Document the patient's bone age: _____ Date of Bone Age Study: _____	
Document the patient's weight: _____Kg	
□ Yes □ No	**If the request is for a non-preferred medication, is there a reason or special circumstance that the patient must be treated with a non-preferred medication?** *If yes, provide reason/special circumstance:*

ADULT GROWTH HORMONE DEFICIENCY *(Continued on next page)*

□ Yes □ No	**Was the diagnosis of adult growth hormone deficiency (GHD) a result of any of the following?** *(If yes, check which applies)* □ Clinical records supporting a diagnosis of childhood-onset GHD □ Adult-onset GHD - clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has undergone any of the following GH stimulation tests to confirm adult GH deficiency?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Arginine (ARG) □ ARG (Arginine) and GHRH (growth hormone releasing hormone) □ Glucagon □ Insulin tolerance test (ITT) □ Macrilen (macimorelin)
□ Yes □ No	**Did the test result in any of the following peak GH values?** *(If yes, check which applies)* □ ITT ≤ 5µg/L □ GHRH+ARG - ≤ 11µg/L if patient BMI < 25kg/m^2 - ≤ 8µg/L if patient BMI ≥ 25kg/m^2 and <30kg/m^2 - ≤4µg/L if patient BMI ≥ 30kg/m^2 □ Glucagon ≤ 3µg/L □ ARG ≤ 0.4µg/L □ Macimorelin < 2.8 ng/mL 30, 45, 60, and 90 minutes following macimorelin administration **If yes, list test and result (and BMI if applicable): _____**
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) be submitted documenting deficiency of any of the following anterior pituitary hormones?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ ACTH (adrenocorticotropic hormone) □ Prolactin □ FSH/LH (follicle-stimulating hormone/luteinizing hormone) □ TSH (thyroid stimulating hormone)

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Agents

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Is the Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab?** *If yes, list IGF-1/Somatomedin-C level and date:*
□ Yes □ No	**Will the requested medication be used in combination with any of the following?** *(If yes, check which applies)* □ Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)] □ Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]
GROWTH FAILURE IN CHILDREN SMALL FOR GESTATIONAL AGE (SGA)	
□ Yes □ No	**Was the diagnosis of SGA (small for gestational age) based on demonstration of catch up growth failure in the first 24 months of life using a birth to 36 month growth chart as confirmed by any of the following?** *(If yes, check which applies)* □ Documentation that birth weight or birth length is below the third percentile for gestational age (greater than or equal to 2 standard deviations [SD] below population mean) □ Patient has demonstrated failure of catch up growth in the first 24 months of life
□ Yes □ No	**Is there documentation that the patient's height remains less than or equal to third percentile (greater than or equal to 2 SD below population mean)?**
GROWTH HORMONE GENE DELETION	
□ Yes □ No	**Has the patient developed neutralizing antibodies to growth hormone?**
□ Yes □ No	**Is there documentation of open epiphyses on last bone radiograph?**
□ Yes □ No	**Will the patient be treated with concurrent growth hormone therapy?**
HIV – ASSOCIATED WASTING SYNDROME OR CACHEXIA	
□ Yes □ No	**Is there documentation of any of the following?** *(If yes, check which applies)* □ Body mass index (BMI) less than 20 kg/m^2 □ Loss of 5% body cell mass (BCM) within 6 months □ Unintentional weight loss of greater than 7.5% over the last 6 months □ Unintentional weight loss greater than 10% over the last 12 months
Document patient's BMI: _____ kg/m^2 & BCM: _____%	
□ Yes □ No	**Has a nutritional evaluation been completed since onset of wasting first occurred?**
□ Yes □ No	**Has the patient had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)?**
□ Yes □ No	**Has the patient's anti-retroviral therapy been optimized to decrease the viral load?**
NOONAN SYNDROME OR TURNER SYNDROME	
□ Yes □ No	**Is the patient's height below the fifth percentile on growth charts for age and gender?**
PEDIATRIC GROWTH FAILURE WITH SHORT-STATURE HOMEBOX (SHOX) GENE DEFICIENCY	
□ Yes □ No	**Was the diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency confirmed by genetic testing?**
PEDIATRIC GROWTH HORMONE DEFICIENCY ***(Continued on next page)***	
□ Yes □ No	**Is the infant less than 4 months of age with growth deficiency?**
□ Yes □ No	**Does the patient have a history of neonatal hypoglycemia associated with pituitary disease?**
□ Yes □ No	**Was the diagnosis of pediatric growth hormone deficiency confirmed by any of the following?** *(If yes, check which applies)* □ Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height □ Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height □ Growth velocity is greater than 2 SD below mean for age and gender □ Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Agents

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) be submitted documenting the patient has undergone any of the following provocative GH stimulation tests?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Arginine □ Clonidine □ Glucagon □ Insulin □ Levodopa □ Growth hormone releasing hormone
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) be submitted documenting GH response values are less than 10 mcg/L?** *(DOCUMENTATION REQUIRED)*
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) be submitted documenting any of the following is below the age and gender adjusted normal range as provided by the physician's lab?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C) □ Insulin Growth Factor Binding Protein-3 (IGFBP-3)
SEVERE PRIMARY IGF-1 DEFICIENCY	
□ Yes □ No	**Is there documentation of any of the following?** *(If yes, check which applies)* □ Basal IGF-1 standard deviation score less than or equal to -3.0 □ Height standard deviation score less than or equal to -3.0 □ Normal or elevated growth hormone levels □ Open epiphyses on the last bone radiograph
□ Yes □ No	**Will the patient be treated with concurrent growth hormone therapy?**
SHORT BOWEL SYNDROME	
□ Yes □ No	**Is the patient currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements)?**
□ Yes □ No	**Has the patient previously received 4 weeks of treatment with Zorbtive?**
TRANSITION PHASE ADOLESCENT PATIENTS	
□ Yes □ No	**Is there documentation of any of the following?** *(If yes, check which applies)* □ Closed epiphyses on bone radiograph □ Patient has attained expected adult height
□ Yes □ No	**Will medical records (e.g., chart notes, laboratory values) be submitted documenting any of the following?** *(If yes, check which applies. DOCUMENTATION REQUIRED)* □ Deficiency of <u>three</u> of the following anterior pituitary hormones: □ ACTH □ FSH/LH □ Prolactin □ TSH □ Embryopathic/congenital defects □ Genetic mutations □ Irreversible structural hypothalamic-pituitary disease □ Panhypopituitarism
□ Yes □ No	**Is the Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab?** *If yes, list IGF-1/Somatomedin-C level and date:*
□ Yes □ No	**Was GH therapy discontinued for at least 1 month?**
□ Yes □ No	**Has the patient undergone any of the following GH stimulation tests after discontinuation of therapy for at least 1 month?** *(If yes, check which applies)* □ Arginine (ARG) □ ARG (Arginine) and GHRH (growth hormone releasing hormone) □ Glucagon □ Insulin tolerance test (ITT)
□ Yes □ No	**Did the test result in any of the following peak GH values?** *(If yes, check which applies)* □ ARG ≤ 0.4µg/L □ ITT ≤ 5µg/L □ Glucagon ≤ 3µg/L □ GHRH+ARG ○ ≤ 11µg/L if patient BMI < 25kg/m^2 ○ ≤ 8µg/L if patient BMI ≥ 25kg/m^2 and <30kg/m^2 ○ ≤4µg/L if patient BMI ≥ 30kg/m^2 **If yes, list test and result (and BMI if applicable):** _____
□ Yes □ No	**Is the patient at low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic GH deficiency)?**

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Agents

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

CONTINUATION OF THERAPY – ADULT GROWTH HORMONE DEFICIENCY	
□ **Yes** □ **No**	**Is there documentation of an IGF-1/Somatomedin C level within the past 12 months?** *If yes, list IGF-1/Somatomedin-C level and date:*
□ **Yes** □ **No**	**Will the requested medication be used in combination with any of the following?** *(If yes, check which applies)* □ Aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole)] □ Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]
CONTINUATION OF THERAPY – GROWTH FAILURE IN CHILDREN SMALL FOR GESTATIONAL AGE (SGA) / NOONAN SYNDROME / PEDIATRIC GROWTH FAILURE ASSOCIATED WITH CHRONIC RENAL INSUFFCIENCY / PEDIATRIC GROWTH FAILURE WITH SHORT-STATURE HOMEBOX (SHOX) GENE DEFICIENCY / TURNER SYNDROME	
□ **Yes** □ **No**	**Was there a height increase of at least 2 cm/year over the previous year?** *If yes, document the following:* **Previous height and date obtained: _____** **Current height and date obtained: _____**
□ **Yes** □ **No**	**Was the expected adult height attained?** *If NO, please document expected adult height goal:*
CONTINUATION OF THERAPY - GROWTH HORMONE GENE DELETION & SEVERE PRIMARY IGF-1 DEFICIENCY	
□ **Yes** □ **No**	**Will the patient be treated with concurrent growth hormone therapy?**
□ **Yes** □ **No**	**Was there a height increase of at least 2 cm/year over the previous year of treatment?** *If yes, document the following:* **Previous height and date obtained: _____** **Current height and date obtained: _____**
□ **Yes** □ **No**	**Was the expected adult height attained?** *If NO, please document expected adult height goal:*
CONTINUATION OF THERAPY - HIV – ASSOCIATED WASTING SYNDROME OR CACHEXIA	
□ **Yes** □ **No**	**Is there evidence of positive response to therapy (i.e., greater than or equal to 2% increase in body weight and/or body cell mass?**
□ **Yes** □ **No**	**Has any of the following targets or goals not been achieved?** *(If yes, check which applies)* □ BCM □ BMI □ Weight
CONTINUATION OF THERAPY - PEDIATRIC GROWTH HORMONE DEFICIENCY	
Document the patient's calculated height (growth) velocity over the past 12 months: _____	
□ **Yes** □ **No**	**Was there a height increase of at least 2 cm/year over the previous year?** *If yes, document the following:* **Previous height and date obtained: _____** **Current height and date obtained: _____**
□ **Yes** □ **No**	**Was the expected adult height attained?** *If NO, please document expected adult height goal (e.g., genetic potential):*
CONTINUATION OF THERAPY- PRADER-WILLI SYNDROME	
□ **Yes** □ **No**	**Is there evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)?**
□ **Yes** □ **No**	**Was there a height increase of at least 2 cm/year over the previous year of treatment?** *If yes, document the following:* **Previous height and date obtained: _____** **Current height and date obtained: _____**
□ **Yes** □ **No**	**Was the expected adult height attained?** *If NO, please document expected adult height goal:*

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Agents

PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

CONTINUATION OF THERAPY - TRANSITION PHASE ADOLESCENT PATIENTS	
□ Yes □ No	**Is there documentation of a positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 [Insulin-like Growth Factor 1] and IGFBP-3 [Insulin-like growth factor binding protein 3] levels)?**

Physician Signature: _____ **Date:** _____