

**Growth Hormone
 Clinical Prior Authorization (PA) Request Form
 CT Medical Assistance Program
 To Be Completed by Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ()	Patient Birth Weight:
Fax ()	Patient Birth Length:
	Patient Current Weight:
	Patient Current Height:
	Patient Primary ICD Diagnosis Code:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>
GENOTROPIN CARTRIDGE	HUMATROPE CARTRIDGE SEROSTIM VIAL
GENOTROPIN MINIQUICK	NGENLA PEN SKYTROFA CARTRIDGE
NORDITROPIN FLEXPRO	NUTROPIN AQ NUSPIN PEN SOGROYA PEN
	OMNITROPE CARTRIDGE ZOMACTON VIAL
	OMNITROPE VIAL

Clinical Information

(attach supporting documentation, required)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a pediatric/adult endocrinologist, nephrologist, clinical geneticist or gastroenterologist (or as appropriate for diagnosis) Please specify subspecialty: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is patient currently using another Somatotropin agent	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please specify alternate agent: _____	
<p>3. Patient has trialed and failed ONE preferred FDA approved agent for the selected indication below for a minimum of 30 days</p> <ul style="list-style-type: none"> ○ Preferred agent trialed: _____ ○ Trial Dates: _____ ○ Reason for Contraindication or Failure: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Initial Approval: Documented diagnosis of ONE of the following:

(attach supporting documentation, required)

<p>Prader-Willi Syndrome – Must meet the following:</p> <ul style="list-style-type: none"> ○ Diagnosis confirmed by genetic testing and fully documented AND ○ Request is for OMNITROPE with documented failure of a preferred agent, either GENOTROPIN or NORDITROPIN (as outlined above in Question 3 of the Clinical Information section) AND ○ Patient NOT severely obese OR have severe respiratory impairment (contraindications to therapy) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Turner Syndrome – Must meet the following:</p> <ul style="list-style-type: none"> ○ Diagnosis confirmed by chromosome analysis and fully documented AND ○ Request is for OMNITROPE, HUMATROPE, NUTROPIN AQ, ZOMACTON with documented failure of a preferred agent, GENOGROPIN or NORDITROPIN (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Noonan Syndrome – Must meet the following:</p> <ul style="list-style-type: none"> ○ Diagnosis confirmed with genetic testing AND ○ Request is for SOGROYA with documented failure of a preferred agent NORDITROPIN (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Short Stature Homeobox-Containing Gene (SHOX) Deficiency – Must meet the following:</p> <ul style="list-style-type: none"> ○ Diagnosis confirmed by genetic testing and fully documented AND 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> ○ Request is for Humatrope or Zomacton 	
<p>Growth Failure in Children Small for Gestational age (SGA) – Must meet the following:</p> <ul style="list-style-type: none"> ○ Documented patient birth weight or length of 2 or more standard deviations below the mean for gestational age and failed to manifest catch up growth by age 2 years (defined as height 2 or more standard deviations below the mean for age and sex) AND ○ Request is for HUMATROPE, OMNITROPE, SOGROYA, OR ZOMACTON with documented failure of a preferred agent, either GENOTROPIN or NORDITROPIN (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Chronic Renal Insufficiency/Chronic Kidney Disease (CKD) – Must meet the following:</p> <ul style="list-style-type: none"> ○ Lack of Renal Transplantation in the past year AND ○ Request is for Nutropin AQ Nuspin 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Idiopathic Short Stature (ISS) with Lack of Other Identifiable Causes of Subnormal Growth (i.e., hypothyroidism, chronic illness, undernutrition, or genetic disorders) – Must meet the following:</p> <ul style="list-style-type: none"> ○ Height is > 2.25 standard deviations below the mean for chronological age and sex and documented growth velocity measured over 1 year is < 5 cm/year AND ○ Request is for HUMATROPE, NUTROPIN AQ NUSPIN, OMNITROPE, SOGROYA, or ZOMACTON with documented failure of a preferred agent, either GENOTROPIN or NORDITROPIN (as outlined above in Question 3 of the Clinical Information section) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Growth Hormone Deficiency (GHD) or growth failure due to inadequate secretion of endogenous growth hormone</p> <ul style="list-style-type: none"> ○ Documented failure of a preferred agent, either GENOTROPIN or NORDITROPIN (as outlined above in Question 3 of the Clinical Information section) AND ● Pediatric patients < 18 years: <ul style="list-style-type: none"> ○ Must meet ONE of the following: <ul style="list-style-type: none"> ▪ Height is > 2 standard deviations below the mean for age and sex and who have poor growth velocity despite adequate control of metabolic abnormalities and good 	<p>Patients < 18 years:</p> <input type="checkbox"/> Yes <input type="checkbox"/> No

<p>nutrition OR</p> <ul style="list-style-type: none"> ▪ Growth velocity is > 2 standard deviations below the mean for chronological age and sex OR ▪ Documentation of suboptimal response (< 10 ng/mL) to any two standard growth hormone stimulation tests (e.g., arginine, clonidine glucagon, propranolol, levodopa, or insulin) OR ▪ Low serum insulin-like growth factor I (IGF-I) defined as below -1 standard deviation and failure of 1 Growth Hormone (GH) stimulation test with GH response value < 10 ng/mL <p>• Adult patients ≥ 18 years:</p> <ul style="list-style-type: none"> ○ Must meet ONE of the following: <ul style="list-style-type: none"> ▪ Low serum insulin-like growth factor I (IGF-I) defined as below -1 standard deviations and failure of GH stimulation test (e.g., insulin, glucagon, arginine, or macimorelin) OR ▪ Failure of 2 GH stimulation tests (e.g., insulin, glucagon, arginine, or macimorelin) 	<p>Patients ≥ 18 years: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>HIV-Associated Cachexia or Wasting – Must meet the following:</p> <ul style="list-style-type: none"> ○ Request is for Serostim AND documentation of AIDS wasting/cachexia with unintentional weight loss of more than 5% body weight in the past 6 months or >10% loss over 12 months (no trial and failure of preferred agents required) 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

<ul style="list-style-type: none"> • Patient previously met the required criteria set forth in Initial Approval Section above <ul style="list-style-type: none"> ○ Previous Approved Prior Authorization Number: _____ ○ Approval Dates: _____ 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<ul style="list-style-type: none"> • Provider has completed the Clinical Information and Initial Approval sections above for ALL Non-Preferred Somatropin formulations 	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>

<p><i>NOTE: Initial therapy requirements apply to both new starts and continued therapy requests for non-preferred somatropin formulations</i></p>	
<ul style="list-style-type: none"> • Patients' clinical response to treatment and ongoing safety has been documented and monitored – Must meet the following: <ul style="list-style-type: none"> ○ Documented change in Height: _____ ○ Documented change in Weight: _____ ○ Documented change in Body Composition: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • Adult patients \geq 18 years of age: – Must meet the following: <ul style="list-style-type: none"> ○ Documentation attached by specialist that discontinuing the requested agent would have a detrimental effect on body composition or other metabolic parameters 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<ul style="list-style-type: none"> • Pediatric patients < 18 years of age: – Must meet the following: <ul style="list-style-type: none"> ○ Documentation attached showing evidence that the epiphyses have not yet closed 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<ul style="list-style-type: none"> • Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen 	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission. I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*: _____ **Date:** _____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**

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