SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

GROWTH HORMONE (rhGH)

(All Growth Hormone medications require a Prior Authorization)

Drug Requested: (Check box below that applies.)

PREFERRED		
❑ Genotropin® cartridge, MiniQuick	❑ Norditropin FlexPro®	
NON-PREFERRED		
❑ Humatrope® cartridge/vial	❑ Ngenla™	❑ Nutropin AQ® NuSpin™
❑ Omnitrope® cartridge/vial	❑ Serostim® vial	❑ Skytrofa™
❑ Sogroya®	❑ Zomacton® vial	

If requesting a non-preferred drug, please document why a PREFERRED drug cannot be used:

_____

_____

Is the drug prescribed by or in consultation with a specialist? (check box that applies)

❑ **Endocrinologist** ❑ **Nephrologist**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

(Continued on next page)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA/DIAGNOSIS: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Idiopathic short stature (ISS)	❑ Pediatric growth hormone (GH) deficiency
❑ Noonan syndrome (NS)	❑ Familial short stature
❑ SHOX deficiency (SHOXD)	❑ Small for gestational age (SGA)
❑ Adult GH deficiency	❑ Turner syndrome (TS)
❑ Prader Willi syndrome (PWS)	❑ Short bowel syndrome (SBS), **skip to diagnosis section**
❑ Chronic renal insufficiency	❑ Pediatric chronic kidney disease, **skip to diagnosis section**
❑ Other: _____	

1. What is member's current height in inches?

   AGE: Years _____ **Month**s: _____ **Height**: _____ **inches**

   Action Required: attach documentation from the medical record of current height.

2. Is this request for a new start, restart **(re -initiation) or** continuation of Growth Hormone (GH) therapy)?

   ❑ New start, **skip to diagnosis section** ❑ Restart, **skip to diagnosis section**

   ❑ Continuation, **skip to renewal section**

(Continued on next page)

Section A: All Pediatric Indications (complete all that apply).

3. Are the growth plates open?

   ❑ Yes ❑ No

4. What is member's pretreatment height and age?

   AGE: Years _____ **Month**s: _____ **Height**: _____ **inches**

   Action Required: attach documentation from the medical record showing pretreatment height and age at measurement.

5. Which of the following criteria does member's pretreatment height meet?

   ❑ Greater than or equal to 2.25 standard deviations (SD) below the mean for age and gender

   ❑ Greater than or equal to 2 standard deviations (SD) below the mean for age and gender

6. What is member's pretreatment growth velocity?

   ❑ Greater than 1 standard deviation (SD) below the mean for age and gender

   ❑ 1 SD below the mean for age and gender

   Action Required: attach documentation from the medical record showing either:

   ❑ At least 2 heights measured by an endocrinologist **at least 6 months** apart (data for at least 1 year)

   ❑ At least 4 heights measured by a primary care physician **at least 6 months** apart (data for at least 2 years)

7. For restart, was the member's growth velocity at least 2cm per year **while on GH therapy**?

   ❑ Yes ❑ No ❑ Not Applicable

Section B: Pediatric GH Deficiency (complete all that apply)

8. Did member have a GH response of less than 10 ng/ml **(or otherwise abnormal as determined by the lab)** of at least 2 GH stimulation tests?

   ❑ Yes ❑ No

   Action Required*:* If **YES**, attach documentation of stimulation test results.

9. Did member have a GH response of less than 15 ng/ml on at least 1 GH stimulation test?

   ❑ Yes ❑ No

   Action Required: attach documentation of GH stimulation test result. If **YES**, please indicate results.

   _____

   _____

10. Does member have a defined CNS pathology, history of cranial irradiation or genetic condition associated GH deficiency?

    ❑ Yes ❑ No

(Continued on next page)

11. Does member have both IGF-1 and IGFBP-3 levels below normal for age and gender?

❑ Yes ❑ No

Action Required: If **YES**, attach documentation from the medical record showing IGF 1 and IGFBP 3 levels below normal.

12. Does member have 2 or more documented pituitary hormone deficiencies other than GH?

❑ Yes ❑ No

13. Did the member have an abnormally low GH level in association with neonatal hypoglycemia?

❑ Yes ❑ No

Action Required: If **YES**, attach documentation of GH level**.**

Section C: Pediatric Chronic Kidney Disease/Chronic Renal Insufficiencies

14. Does member have any of the following? (**Indicate any/all that apply***)*

❑ Creatinine clearance of 75 mL/min/1.73m2 or less
❑ Dialysis dependency
❑ Serum creatinine greater than 3.0 g/dL
❑ None of the above

Section D: Pediatric Chronic Kidney Disease

15. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?

❑ New start, **no further questions** ❑ Restart ❑ Continuation

16. Was GH therapy previously approved for this member?

❑ Yes ❑ No

17. What is the member's current height in inches? _____

Action Required*:* attach documentation from the medical record of current height. If **Restart,** no further questions.

18. Is member's growth velocity at least 2 cm per year while on GH therapy?

❑ Yes ❑ No

Action Required: If **YES**, attach documentation from medical record supporting growth velocity of at least 2 cm/year.

(Continued on next page)

Section E: Adult GH Deficiency:

19. Does member have irreversible hypothalamic/pituitary structural lesions or ablation?

❑ Yes ❑ No

If **YES**, no further questions.

20. Does member have a defect in GH synthesis?

❑ Yes ❑ No

If **YES**, no further questions.

21. Did the member have GH deficiency diagnosed during childhood?

❑ Yes ❑ No

22. Does the member have 3 or more pituitary hormone deficiencies?

❑ Yes ❑ No

23. Was the member retested for GH deficiency after at least 1-month break in GH therapy?

❑ Yes ❑ No

24. Which of the following pharmacologic agents was used in a GH stimulation test to measure peak GH levels?

❑ Insulin	❑ Clonidine	❑ Levodopa	❑ Glucagon
❑ Arginine	❑ GH stimulation test not performed	❑ Other: _____	

Action Required: attach documentation showing the results of GH stimulation test.

25. Indicate the peak GH level**:** _____ng/ml

26. Is pretreatment IGF-1 level below the laboratory's normal range?

❑ Yes ❑ No

Action Required: attach documentation from the medical record showing the member's pretreatment IGF- 1 level.

(Continued on next page)

Section F: Short Bowel Syndrome

27. Is member receiving specialized nutritional support?

❑ Yes ❑ No

28. Will GH be used in conjunction with optimal management of short-bowel syndrome?

❑ Yes ❑ No

29. How many months of GH therapy has the member received?

❑ **Months:** _____ ❑ **Not Applicable/New start**

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

1. Has the member experienced a therapeutic benefit from the requested medication?

❑ Yes ❑ No

2. Does the member continue to meet applicable initial criteria?

❑ Yes ❑ No

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~6/30/2017; 8/29/2017; 8/19/2018; 1/2/2019; 4/2/2019; 12/24/2019; 12/21/2020, 6/8/22; 6/29/2022; 12/21/2023; 6/07/2024;8/20/2024;~~**9/21/2026**