



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

Growth Hormone 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Member ID:		City:		State:	
				Height:	
				Weight:	
Prescribing Provider Information					
Provider Name (first & last):		Specialty:		NPI#	
Office Address:		City:		State:	
Office Contact:		Office Phone		Office Fax:	
				DEA#	
				Zip Code:	
Dispensing Pharmacy Information					
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information					
Preferred Agents:		<input type="checkbox"/> Norditropin		<input type="checkbox"/> Genotropin	
Non-Preferred Agents:		<input type="checkbox"/> Omnitrope Vials		<input type="checkbox"/> Humatrope	
		<input type="checkbox"/> Saizen		<input type="checkbox"/> Serostim	
		<input type="checkbox"/> Tev-Tropin		<input type="checkbox"/> Nutropin	
		<input type="checkbox"/> Valtropin		<input type="checkbox"/> Zorbtive (somatropin)	
				<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"/> Urgent – 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					
Was there inability OR disability to use vial formulation (example: visual impairment)?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was treatment for indication not supported by preferred Growth Hormone product?	
Was there history of neonatal hypoglycemia associated with pituitary disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Was there history of irradiation, surgery OR trauma to hypothalamic-pituitary area?	
Was there defined CNS pathology confirmed by MRI or CT?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Pediatric Growth Hormone Deficiency					

Is height >2 standard deviations below mid parental height (projected height)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is height >2.25 standard deviations below population mean for age and gender?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is growth velocity >2 standard deviations below population mean for age and gender?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is bone age compared to chronological age \geq 2 standard deviations below mean for age and gender?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Has member undergone 2 GH stimulation tests (for example, Arginine, Clonidine, Glucagon, Insulin, Levodopa, GhRh)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Were GH response values < 10 mcg/L?	
Was ONE abnormal GH test enough for child with defined CNS pathology, multiple pituitary hormone deficiency, history of irradiation OR genetic defect affecting GH axis?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is member < 1 year of age 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	<input type="checkbox"/> N/A
Are epiphyses open (confirming open growth plates in members who are over 12 years of age)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Were other pituitary hormone deficiencies ruled out (for example, hypothyroidism, chronic ischemic disease)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Renewal Request ONLY:							
Did provider submit documentation for previous height, current height AND expected adult height goal?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did height increase at least 2.5cm per year OR 4.5cm per year?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was expected final height NOT achieved?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is bone age <16 years for males OR <14 years for female?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are growth (epiphyseal) plates still open?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Prader-Willi Syndrome							
Is epiphyses open (confirmation of open growth plates in member > 12 years of age)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is growth velocity >2 standard deviations below population mean for age AND gender?	
<input type="checkbox"/> Renewal Request ONLY:							
Is there documentation supporting positive response to therapy (for example, increase in total lean body mass, decrease in fat mass) OR above growth hormone renewal requirements are met?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Turner Syndrome							
Is this request for a Female that is >2 years of age AND bone age is <14 years?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is growth velocity >2 standard deviations below population mean for age and gender?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are Epiphyses open (confirmation of open growth plates in patients over 12 years of age)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Noonan Syndrome							
Is GV >2 standard deviation below population mean for age AND gender?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is bone age compared to chronological age \geq 2 standard deviations below mean for age AND gender?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are epiphyses open (confirmation of open growth plates in member over 12 years of age)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Short Stature with SHOX Deficiency							
Was diagnosis confirmed by genetic testing?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is bone age compared to chronological age \geq 2 standard deviations below mean for age AND gender?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Epiphyses are open (confirmation of open growth plates in patients over 12 years of age)?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is GV >2 standard deviations below population mean for age AND gender?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Growth Failure with Chronic Renal Insufficiency OR Chronic Kidney Disease Prior to Renal Transplantation							
Prior to start with GH therapy, were the existing metabolic derangements such as malnutrition, zinc deficiency AND secondary hyperparathyroidism corrected?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was bone age compared to chronological age \geq 2 standard deviations below mean for age and gender?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is growth velocity >2 standard deviations below population mean for age and gender?		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Growth Failure in Children Small for Gestational Age							
Did child fail to achieve catch up growth in first 24 months of life (by 2 years of age) 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	Did member height remain below 3rd percentile (> 2 standard deviations below population age AND gender)?		
<input type="checkbox"/> Renewal Request ONLY:							
Did provider submit documentation for previous height, current height AND expected adult height goal?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did height increase at least 2.5cm per year OR 4.5cm per year?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was expected final height NOT achieved?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is bone age <16 years for males OR <14 years for female?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are growth (epiphyseal) plates still open?					<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Transition Phase Adolescent Members							

Is adolescent between ages 10 to 19 as defined by World Health Organization?					<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Did member attain expected adult height?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did bone radiograph show 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"/> Hypothalamic-Pituitary structural defect or tumor		<input type="checkbox"/> At least 3 deficiencies of anterior pituitary hormones (FSH / LH, TSH, ACTH, Prolactin), pan-hypopituitarism		<input type="checkbox"/> Genetic cause of GH					
Is IGF-1 below age AND gender adjusted normal range as provided by physician's lab?					<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"/> ≤5 ng/ml		<u>Glucagon:</u> <input type="checkbox"/> ≤3 ng/mL		<u>Arginine:</u> <input type="checkbox"/> ≤0.4 ng/mL				
			<u>Arginine + GHRH:</u> <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								
<input type="checkbox"/> Renewal Request ONLY:											
Is there documentation supporting positive response to therapy (for example, increase in total lean body mass, increased exercise capacity OR increased IGF-1 levels) AND documentation is submitted with request?					<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No					
<input type="checkbox"/> Adult Growth Hormone Deficiency											
Did provider submit documentation supporting diagnosis, stim test results, and IGF-1 levels?					<input type="checkbox"/> Yes	<input type="checkbox"/> No					
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				
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				
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		Macimorelin: <input type="checkbox"/> ≤2.8 ng/mL	
Is there at least 3 deficiency of anterior pituitary hormones (FSH/LH, TSH, ACTH, Prolactin), pan-hypopituitarism?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is IGF-1 below age AND gender adjusted normal range as provided by physician's lab?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
<input type="checkbox"/> Renewal Request ONLY:											
Is there documentation supporting positive response to therapy (for example, increase in total lean body mass, increased exercise capacity OR increased IGF-1 levels) AND documentation is submitted with request?					<input type="checkbox"/> Yes	<input type="checkbox"/> No					
<input type="checkbox"/> HIV-Associated Cachexia or Wasting											
Is there documentation of BMI, weight, and ideal body weight prior to start of therapy and then after starting Serostim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member on current use of anti-retroviral therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Was there inadequate response, intolerable side effects, or contraindication to megestrol acetate or dronabinol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the BMI <20 kg/m2 prior to starting Serostim?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
Was there weight loss due to other causes such as depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with exception of Kaposi's sarcoma limited to skin or mucous membranes?					<input type="checkbox"/> Yes	<input type="checkbox"/> No					
Member has unintentional weight loss of >10% over last 12 months or >5% over last 6 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is weight <90% of the lower limit of ideal body weight?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
<input type="checkbox"/> Renewal Request ONLY:											
Is there documentation supporting positive response to therapy (BMI has improved or stabilized)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member on current anti-retroviral therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No				
<input type="checkbox"/> Short Bowel Syndrome											
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				
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.