



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with fields: Patient Name, Prescriber Name, Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Phone, Office Contact, NPI, State Lic ID, Specialty/facility name (if applicable).

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Form with fields: Drug Name, Strength, Directions / SIG.

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this drug being prescribed by or in consultation with an appropriate specialist (e.g., neonatologist [in the neonatal period], endocrinologist, gastroenterologist, or nephrologist)? If YES go to 2.

- Initial, Continuation

Q2. Is this an initial or reauthorization request? If an initial request, go to 3. If reauthorization request, go to 19.

- Yes, No

Q3. What is the diagnosis?

- Pediatric GH Deficiency - go to 4, Small for Gestational Age - go to 6, Turner Syndrome - go to 7, Growth Failure Associated with Chronic Kidney Disease (CKD), Cerebral Palsy, Congenital Adrenal Hyperplasia, Cystic Noonan Syndrome - go to 10, Short Stature Homeobox-Containing Gene Deficiency - go to 11, Adult GH Deficiency - go to 12, HIV-Associated Wasting/Cachexia - go to 17, Short Bowel Syndrome - go to 18

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Fibrosis, and Russell-Silver Syndrome - go to 8

Prader-Willi Syndrome - go to 9

Q4. For pediatric GH deficiency, does the patient meet the following criteria? Please submit documentation and applicable labs. If NO, go to 5.

a. Patient is a neonate or was diagnosed with GH deficiency as a neonate. Medical records must be submitted to support the diagnosis of neonatal GH deficiency (e.g., hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiency, chart notes, or MRI results).

Yes

No

Q5. For pediatric GH deficiency, please select ALL that apply. Must submit documentation and applicable labs.

Patient has two pretreatment pharmacologic provocative GH tests with both results demonstrating a peak GH level < 10 ng/mL.

Patient has a documented pituitary or CNS disorder and a pretreatment IGF-1 level > 2 standard deviations (SD) below the mean.

For patients greater than or equal to 2.5 years of age at initiation of treatment, the pretreatment height is > 2 SD below the mean and growth velocity is slow.

For patients greater than or equal to 2.5 years of age at initiation of treatment: Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean.

For patients less than or equal to 2.5 years of age at initiation of treatment: Pretreatment 1-year height velocity is > 2 SD below the mean.

Epiphyses are open

Q6. For small for gestational age, select ALL that apply. Please submit documentation and applicable labs.

Birth weight < 2500 g at gestational age > 37 weeks

Birth weight or length less than 3rd percentile for gestational age

Birth weight or length greater than or equal to 2 SD below the mean for gestational age

Pretreatment age is greater than or equal to 2 years



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
<input type="checkbox"/> Patient failed to manifest catch-up growth by age 2 (i.e., pretreatment height > 2 SD below the mean) <input type="checkbox"/> Epiphyses are open	
Q7. For Turner syndrome, select ALL that apply. Please submit documentation and applicable labs. <input type="checkbox"/> Diagnosis was confirmed by karyotyping. <input type="checkbox"/> Patient's pretreatment height is less than the 5th percentile for age. <input type="checkbox"/> Epiphyses are open.	
Q8. For growth failure associated with CKD, cerebral palsy, congenital adrenal hyperplasia, cystic fibrosis, and Russell-Silver Syndrome, please select ALL that apply. Please submit documentation and applicable labs. <input type="checkbox"/> For patients < 2.5 years of age at initiation of treatment, the pretreatment height is > 2 SD below the mean and growth velocity is slow <input type="checkbox"/> For patients greater than or equal to 2.5 years of age at initiation of treatment: Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean. <input type="checkbox"/> For patients greater than or equal to 2.5 years of age at initiation of treatment: Pretreatment 1-year height velocity is > 2 SD below the mean. <input type="checkbox"/> Epiphyses are open.	
Q9. For Prader-Willi Syndrome, has the diagnosis been confirmed by genetic testing demonstrating ANY of the following? Select ALL that apply. Please submit documentation and applicable labs. <input type="checkbox"/> Deletion in the chromosomal 15q11.2-q13 region <input type="checkbox"/> Maternal uniparental disomy in chromosome 15 <input type="checkbox"/> Imprinting defects, translocations, or inversions involving chromosome 15	
Q10. For Noonan Syndrome, select ALL that apply to the patient. Please submit documentation and applicable labs.	

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean OR pretreatment 1-year height velocity is > 2 SD below the mean
 Epiphyses are open

Q11. For Short Stature Homeobox-Containing Gene Deficiency, select ALL that apply to the patient. Please submit documentation and applicable labs.

- The diagnosis of SHOX deficiency was confirmed by molecular or genetic analyses
- Pretreatment height is > 2 SD below the mean and 1-year height velocity is > 1 SD below the mean OR pretreatment 1-year height velocity is > 2 SD below the mean
- Epiphyses are open

Q12. For adult GH deficiency, does the patient meet both of the following in a) and b)? Please submit documentation and applicable labs.

- Patient has had 2 pretreatment pharmacologic provocative GH tests and both results demonstrated deficient GH responses defined as the following:
 - A) Insulin tolerance test (ITT) with a peak GH level less than or equal to 5 ng/mL
 - B) Macrilen with a peak GH level of < 2.8 ng/mL
 - C) Glucagon stimulation test with a peak GH level less than or equal to 3.0 ng/mL in patients with a body mass index (BMI) less than or equal to 30 kg/m² and a high pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI < 25 kg/m²
 - D) Glucagon stimulation test with a peak GH level less than or equal to 1.0 ng/mL in patients with a BMI of greater than or equal to 25 kg/m² and a low pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI > 30 kg/m².
- Patient has a low pretreatment IGF-1 (between 0 to 2 SD below the mean for age and gender).

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Q13. For adult GH deficiency, does the patient meet both of the following in a) and b)? Please submit documentation and applicable labs. If YES, approve for 12 months. If NO, go to 14.

- Patient has had 1 pretreatment pharmacologic provocative GH test that demonstrated deficient GH responses defined as one of the following:
- A) Insulin tolerance test (ITT) with a peak GH level less than or equal to 5 ng/mL
 - B) Macrilen with a peak GH level of < 2.8 ng/mL
 - C) Glucagon stimulation test with a peak GH level less than or equal to 3.0 ng/mL in patients with a body mass index (BMI) = less than or equal to 30 kg/m² and a high pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI < 25 kg/m²
 - D) Glucagon stimulation test with a peak GH level less than or equal to 1.0 ng/mL in patients with a BMI of greater than or equal to 25 kg/m² and a low pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI > 30 kg/m².

Patient has a pretreatment IGF-1 level that is > 2 SD below the mean for age and gender

Q14. For adult GH deficiency, does the patient have organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 documented pituitary hormone deficiencies (refer to Appendix B) and a low pretreatment IGF-1 that is > 2 standard deviations below the mean for age and gender? Please submit documentation and applicable labs. If YES, approve for 12 months. If NO, go to 15.

Yes

No

Q15. For adult GH deficiency, does the patient have genetic or structural hypothalamic-pituitary defects? Please submit documentation and applicable labs. If NO, go to 16.

Yes

No

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

Q16. For adult GH deficiency, does the patient have childhood-onset GH deficiency and a congenital abnormality of the CNS, hypothalamus or pituitary? Please submit documentation and applicable labs.

Yes

No

Q17. For HIV-associated wasting or cachexia, select ALL the criteria that applies to the patient. Please submit documentation and applicable labs.

Patient has trialed and experienced a suboptimal response to alternative therapies (e.g., cyproheptadine, dronabinol, megestrol acetate or testosterone if hypogonadal) or contraindication or intolerance to alternative therapies

Patient is currently on antiretroviral therapy

BMI is < 18.5 kg/m² prior to starting therapy with growth hormone

Q18. For short bowel syndrome, does the patient depend on intravenous parenteral nutrition for nutritional support when GH will be used in conjunction with optimal management of SBS?

Yes

No

Q19. For reauthorization, what is the diagnosis:

Pediatric GH Deficiency - go to 20

Small for Gestational Age - go to 20

Turner Syndrome - go to 20

Growth Failure Associated with Chronic Kidney Disease (CKD), Cerebral Palsy, Congenital Adrenal Hyperplasia, Cystic Fibrosis, and Russell-Silver Syndrome – go to 19

Prader-Willi Syndrome – go to 20

Noonan Syndrome – go to 19

Short Stature Homeobox-Containing Gene Deficiency – go to 19

Adult GH Deficiency – go to 21

HIV-Associated Wasting/Cachexia – go to 26

Q20. For Pediatric GH Deficiency, Turner Syndrome, Noonan Syndrome, CKD, SGA, SHOX deficiency, Congenital Adrenal Hyperplasia, Cerebral Palsy, Cystic Fibrosis, and Russell-Silver Syndrome, does the patient meet both of the following criteria?

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

<input type="checkbox"/> Epiphyses are open (confirmed by X-ray or X-ray is not available)	<input type="checkbox"/> Patient's growth rate is > 2 cm/year unless there is a documented clinical reason for lack of efficacy (e.g., on treatment less than 1 year, nearing final adult height/late stages of puberty)
--	--

Q21. For Prader-Willi Syndrome, has the patient's body composition and psychomotor function improved or stabilized in response to GH therapy?

Yes
 No

Q22. For adult GH deficiency, does the patient meet all of the following criteria? Please submit documentation and applicable labs. If NO, go to 23.

Patient has had 2 pretreatment pharmacologic provocative GH tests and both results demonstrated deficient GH responses defined as the following:
 A) Insulin tolerance test (ITT) or another provocative GH test with a peak GH level less than or equal to 5 ng/mL
 B) Macrilen with a peak GH level of < 2.8 ng/mL
 C) Glucagon stimulation test with a peak GH level less than or equal to 3.0 ng/mL in patients with a body mass index (BMI) less than or equal to 30 kg/m² and a high pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI < 25 kg/m²
 D) Glucagon stimulation test with a peak GH level less than or equal to 1.0 ng/mL in patients with a BMI of greater or equal to 25 kg/m² and a low pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI > 30 kg/m².

Patient has a low pretreatment IGF-1 (between 0 to 2 SD below the mean for age and gender).

Current IGF-1 level is not elevated for age and gender.

Q23. For adult GH deficiency, does the patient meet all of the following criteria? Please submit documentation and applicable labs. If NO, go to 24.

Patient has had 1 pretreatment pharmacologic provocative GH test that demonstrated deficient GH responses defined as one of the following:
 A) Insulin tolerance test (ITT) or another provocative GH test with a peak GH level = 5 ng/mL
 B) Macrilen with a peak GH level of < 2.8 ng/mL
 C) Glucagon stimulation test with a peak GH level = less than or equal to 3.0 ng/mL in patients with a body mass index (BMI) = less than or equal to 30 kg/m² and a high pretest probability of



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

GHD (e.g., acquired structural abnormalities) OR a BMI < 25 kg/m²

D) Glucagon stimulation test with a peak GH level = less than or equal to 1.0 ng/mL in patients with a BMI of = greater than or equal to 25 kg/m² and a low pretest probability of GHD (e.g., acquired structural abnormalities) OR a BMI > 30 kg/m²

- Patient has a pretreatment IGF-1 level that is > 2 SD below the mean for age and gender
- Current IGF-1 level is not elevated for age and gender

Q24. For adult GH deficiency, does the patient meet both of the following criteria? Please submit documentation and applicable labs. If NO, go to 25.

- Patient has organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with greater than or equal to 3 documented pituitary hormone deficiencies and a low pretreatment IGF-1 that is greater than 2 standard deviations below the mean for age and gender
- Current IGF-1 level is not elevated for age and gender

Q25. Does the patient have genetic or structural hypothalamic-pituitary defects and current IGF-1 level is not elevated for age and gender? If NO, go to 26.

- Yes
- No

Q26. Does the patient have childhood-onset GH deficiency and a congenital abnormality of the CNS, hypothalamus or pituitary and current IGF-1 level is not elevated for age and gender?

- Yes
- No

Q27. For HIV-associated wasting or cachexia, select ALL that apply to the patient. Please submit documentation and applicable labs.

- Patient is diagnosed with HIV-associated wasting/cachexia
- Patient is currently on antiretroviral therapy
- Patient is currently receiving treatment with growth hormone excluding obtainment as samples or via manufacturer's patient assistance programs
- Current BMI is < 27 kg/m²?



PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Growth Hormones

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:
----------------------	-------------------------

<p>Q28. Additional Information:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Prescriber Signature

Date

v2026