Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Growth Hormones

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid		
□ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 the patient 18 years of age or older?

☐ Yes ☐ No

Q2. Has the patient been diagnosed with growth failure due to growth hormone deficiency (GHD), including at least one of the following? Documentation must be attached: 1. Subnormal response to at least two provocative GH stimulation tests (resulting in peak GH levels <10 ng/mL); or 2. Subnormal response to at least one provocative GH stimulation test (resulting in peak GH level <10 ng/mL) AND subnormal insulin-like growth factor-1 (IGF-1) level; or 3. Subnormal IGF-1 level AND panhypopituitarism (defined as deficiencies of at least 3 other pituitary hormones), pituitary disease, hypothalamic disease, hypothalamic/pituitary surgery, radiation therapy, or trauma.

☐ Yes ☐ No

Q3. Has the patient been diagnosed with short stature associated with Noonan syndrome, including genetic testing and member characteristics consistent with diagnosis? Documentation must be attached.

☐ Yes ☐ No

Q4. Has the patient been diagnosed with short stature associated with Turner syndrome, including genetic testing consistent with diagnosis? Documentation must be attached.

☐ Yes ☐ No

Q5. Has the patient been diagnosed with short stature born small for gestational age (SGA) with no catch-up growth by age 2-4 years? Documentation must be attached.

☐ Yes ☐ No

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Growth Hormones

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**

Q6. Has the patient been diagnosed with growth failure due to Prader-Willi syndrome (PWS)? Documentation must be attached (clinical symptoms and blood test confirmation via "methylation analysis").

☐ Yes ☐ No

Q7. Has the patient been diagnosed with growth failure or short stature due to any of the following conditions: idiopathic short stature, familial short stature (FSS) or constitutional delay of growth and puberty (CDGP)?

☐ Yes ☐ No

Q8. Has the diagnosis been made and documented by an endocrinologist?

☐ Yes ☐ No

Q9. Is documentation attached including growth chart, height, chronological age, and bone age (if available)?

☐ Yes ☐ No

Q10. Is the request for Norditropin?

☐ Yes ☐ No

Q11. Has the patient tried and failed Norditropin? Please include documentation of Norditropin use, with dose, dates/duration of use, and specific outcome.

☐ Yes ☐ No

Q12. Is the prescriber requesting a non-preferred formulation of growth hormone (somatropin) for an indication not included in the prescribing information for Norditropin?

☐ Yes ☐ No

Q13. Has the prescriber provided documentation of an FDA-approved indication consistent with prescribing information for the non-preferred formulation of somatropin and current medical literature? Please attach necessary documentation, including medical records, genetic testing, and clinical literature, as applicable.

☐ Yes ☐ No

Q14. Does the patient have GHD as a result of one of the following: panhypopituitarism (defined as deficiencies of at least 3 other pituitary hormones), pituitary disease, hypothalamic disease, hypothalamic/pituitary surgery, radiation therapy, or trauma?

☐ Yes ☐ No

Q15. Has the patient had a subnormal response to at least one provocative GH stimulation test (resulting in peak GH level <5 ng/mL) OR a subnormal insulin-like growth factor-1 (IGF-1) level while off of growth hormone therapy for at least 1 month? Documentation must be attached.

☐ Yes ☐ No

Q16. Has the patient's growth hormone deficiency been confirmed as an adult before replacement therapy is started, including subnormal responses to at least two standard provocative growth hormone stimulation tests (resulting in peak

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Growth Hormones

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**

GH level <5 ng/mL) while off of growth hormone therapy for at least 1 month? Or has AGHD been confirmed by oral Macimorelin stimulation test (approved by FDA in December 2017)? Documentation must be attached.

☐ Yes ☐ No

Q17. Is the request for Norditropin?

☐ Yes ☐ No

Q18. Has the patient tried and failed Norditropin? Please include documentation of Norditropin use, with dose, dates/duration of use, and specific outcome.

☐ Yes ☐ No

Q19. Requested Duration:

☐ 12 Months

Q20. Additional Information:

Prescriber Signature

Date

Updated 2018