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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Genotropin® Prior Authorization Request Form (Page 1 of 4)

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Member Information (required)			Provider Information (required)																
Member Name:			Provider Name:																
Insurance ID#:			NPI#:		Specialty:														
Date of Birth:			Office Phone:																
Street Address:			Office Fax:																
City:	State:	Zip:	Office Street Address:																
Phone:			City:	State:	Zip:														
Medication Information (required)																			
Medication Name:			Strength:		Dosage Form:														
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:																
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>																			
Clinical Information (required)																			
<p><b>Select the diagnosis below:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Growth hormone deficiency in adults</td> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Pediatric growth hormone deficiency</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Growth hormone deficiency in transition phase adolescents</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Prader-Willi syndrome</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Idiopathic short stature (ISS)</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Small for gestational age (SGA)</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Isolated growth hormone deficiency in adults</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Short-stature homeobox (SHOX) gene deficiency</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Noonan syndrome</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Turner syndrome</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency</td> <td></td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Other diagnosis: _____</td> <td style="vertical-align: top; padding: 2px;">ICD-10 Code(s): _____</td> </tr> </table>						<input type="checkbox"/> Growth hormone deficiency in adults	<input type="checkbox"/> Pediatric growth hormone deficiency	<input type="checkbox"/> Growth hormone deficiency in transition phase adolescents	<input type="checkbox"/> Prader-Willi syndrome	<input type="checkbox"/> Idiopathic short stature (ISS)	<input type="checkbox"/> Small for gestational age (SGA)	<input type="checkbox"/> Isolated growth hormone deficiency in adults	<input type="checkbox"/> Short-stature homeobox (SHOX) gene deficiency	<input type="checkbox"/> Noonan syndrome	<input type="checkbox"/> Turner syndrome	<input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency		<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____
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<input type="checkbox"/> Pediatric growth failure associated with chronic renal insufficiency																			
<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____																		
<p><b>Clinical Information:</b></p> <p>Select if the requested medication is prescribed by one of the following specialists:</p> <p><input type="checkbox"/> Endocrinologist      <input type="checkbox"/> Nephrologist (for patients with chronic renal insufficiency)</p> <p>Select if the patient has history of trial and failure, contraindication or intolerance to the following:</p> <p><input type="checkbox"/> Norditropin FlexPro      <input type="checkbox"/> Nutropin AQ Nuspin      <input type="checkbox"/> Omnitrope</p>																			
<p><b>For pediatric growth hormone deficiency, also answer the following:</b></p> <p>Is the patient an infant less than 4 months of age? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the infant have growth deficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have neonatal hypoglycemia associated with pituitary disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have panhypopituitarism? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Select if the patient has pediatric growth hormone deficiency as confirmed by the following:</p> <p><input type="checkbox"/> Patient's height is greater than 2.0 standard deviations [SD] below mid-parental height (utilizing age and gender growth charts related to height)</p> <p><input type="checkbox"/> Patient's height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) (utilizing age and gender growth charts related to height)</p> <p><input type="checkbox"/> Patient's growth velocity is greater than 2 SD below mean for age and gender</p> <p><input type="checkbox"/> Delayed skeletal maturation greater than 2 SD below mean for age and gender (e.g., delayed more than 2 years compared with chronological age)</p> <p>Is there documentation the patient's bone age is less than 16 years for males or less than 14 years for females? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																			
<p><b>Reauthorization:</b></p> <p>Has the expected adult height been reached? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Document the expected adult height goal: _____</p>																			

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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## Genotropin® Prior Authorization Request Form (Page 2 of 4)

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### For growth hormone (GH) deficiency in adults, also answer the following:

Are there clinical records supporting a diagnosis of childhood-onset GH deficiency?  Yes  No

Is the diagnosis adult-onset GH deficiency?  Yes  No

Are there clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)?  Yes  No

Select if the patient has undergone the following GH stimulation tests to confirm adult GH deficiency and the peak GH value is as follows:

- Insulin tolerance test (ITT) less than or equal to 5 mcg/L
- Arginine & GH-releasing hormone (ARG+GHRH) less than or equal to 11 mcg/L if body mass index (BMI) is less than 25 kg/m<sup>2</sup>; less than or equal to 8 mcg/L if BMI is greater than or equal to 25 kg/m<sup>2</sup> and less than 30 kg/m<sup>2</sup>; less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m<sup>2</sup>
- Glucagon less than or equal to 3 mcg/L
- Arginine (ARG) less than or equal to 0.4 mcg/L

Select if the patient has documented deficiency of the following anterior pituitary hormones:

- Prolactin
- Thyroid stimulating hormone (TSH)
- Adrenocorticotropic hormone (ACTH)
- Follicle-stimulating hormone/luteinizing hormone (FSH/LH)

Is the IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab?  Yes  No

Does the patient have panhypopituitarism?  Yes  No

Select if the patient will be using the requested medication in combination with the following:

- Aromatase inhibitors (e.g., Arimidex [anastrozole], Femara [letrozole])
- Androgens (e.g., Delatestryl [testosterone enanthate], Depo-Testosterone [testosterone cypionate])

### Reauthorization:

Is there evidence of ongoing monitoring as demonstrated by documentation within the past 12 months of an IGF-1/Somatomedin-C level?  Yes  No

Does the patient have panhypopituitarism?  Yes  No

Select if the patient will be using the requested medication in combination with the following:

- Aromatase inhibitors (e.g., Arimidex [anastrozole], Femara [letrozole])
- Androgens (e.g., Delatestryl [testosterone enanthate], Depo-Testosterone [testosterone cypionate])

### For growth hormone (GH) deficiency in transition phase adolescents, also answer the following:

Has the expected adult height been reached?  Yes  No

Does the patient have closed epiphyses on bone radiograph?  Yes  No

Select if there is documentation of high risk of GH deficiency due to GH deficiency in childhood from the following:

- Embryopathic/congenital defects
- Irreversible structural hypothalamic-pituitary disease
- Genetic mutations
- Panhypopituitarism
- Deficiency of **three** of the following pituitary hormones: ACTH, TSH, Prolactin, FSH/LH

Is the IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab?  Yes  No

Has GH therapy been discontinued for at least 1 month?  Yes  No

Is the patient at low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic deficiency)?  Yes  No

Select if the patient has undergone the following GH stimulation tests to confirm adult GH deficiency after discontinuation of therapy for at least 1 month and the peak GH value is as follows:

- Insulin tolerance test (ITT) less than or equal to 5 mcg/L
- Arginine & GH-releasing hormone (ARG+GHRH) less than or equal to 11 mcg/L if body mass index (BMI) is less than 25 kg/m<sup>2</sup>; less than or equal to 8 mcg/L if BMI is greater than or equal to 25 kg/m<sup>2</sup> and less than 30 kg/m<sup>2</sup>; less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m<sup>2</sup>
- Glucagon less than or equal to 3 mcg/L
- Arginine (ARG) less than or equal to 0.4 mcg/L

### Reauthorization:

Is there evidence the patient has had a positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 and IGFBP-3 levels)?  Yes  No



## Genotropin® Prior Authorization Request Form (Page 3 of 4)

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### For idiopathic short stature (ISS), also answer the following:

Has there been diagnostic evaluation that has excluded other causes associated with short stature (e.g., growth-hormone deficiency, chronic renal insufficiency, etc.)?  Yes  No

Is there documentation the patient has a height less than or equal to -2.25 standard deviation score (SDS) below the corresponding mean height for age and gender?  Yes  No

Is there documentation the patient's growth velocity is less than the 25<sup>th</sup> percentile for bone age?  Yes  No

Is there documentation the patient's bone age is less than 16 years for males or less than 14 years for females?  Yes  No

#### Reauthorization:

Has the expected adult height been reached?  Yes  No

Document the expected adult height goal: \_\_\_\_\_

### For isolated growth hormone deficiency in adults, also answer the following:

Is there documentation the patient has deficiency of GH defined by a failure to produce a peak serum GH level of greater than 5 mcg/L after provocative pharmacologic stimulation by **two** of the following tests: Insulin, L-arginine, and/or glucagon?  Yes  No

#### Reauthorization:

Is there evidence of ongoing monitoring as demonstrated by documentation within the past 12 months of an IGF-1/Somatomedin-C level?  Yes  No

### For pediatric growth failure associated with chronic renal insufficiency, also answer the following:

Is there documentation the patient's bone age is less than 16 years for males or less than 14 years for females?  Yes  No

#### Reauthorization:

Has the expected adult height been reached?  Yes  No

Document the expected adult height goal: \_\_\_\_\_

### For Prader-Willi syndrome, also answer the following:

#### Reauthorization:

Is there evidence the patient has had a positive response to therapy (e.g., increase in total lean mass, decrease in fat mass)?  Yes  No

Has the expected adult height been reached?  Yes  No

Document the expected adult height goal: \_\_\_\_\_

### For small for gestational age (SGA), also answer the following:

Select if the diagnosis of SGA is based on demonstration of catch up growth failure in the first 24 months of life using a 0-36 month growth chart as confirmed by the following:

Patient's birth **weight** was below the 3<sup>rd</sup> percentile for gestational age (more than 2 SD below population mean)

Patient's birth **length** was below the 3<sup>rd</sup> percentile for gestational age (more than 2 SD below population mean)

Patient's **height** remains less than or equal to the 3<sup>rd</sup> percentile (more than 2 SD below population mean)

#### Reauthorization:

Has the expected adult height been reached?  Yes  No

Document the expected adult height goal: \_\_\_\_\_

### For short-stature homeobox (SHOX) gene deficiency, also answer the following:

Does the patient have pediatric growth failure with short stature homeobox (SHOX) gene deficiency as confirmed by genetic testing?  Yes  No

Is there documentation the patient's bone age is less than 16 years for males or less than 14 years for females?  Yes  No

#### Reauthorization:

Has the expected adult height been reached?  Yes  No

Document the expected adult height goal: \_\_\_\_\_

### For Turner syndrome (gonadal dysgenesis) or Noonan syndrome, also answer the following:

Is there documentation the patient's bone age is less than 16 years for males or less than 14 years for females?  Yes  No

Is the patient's height below the 5<sup>th</sup> percentile on growth charts for age and gender?  Yes  No

#### Reauthorization:

Has the expected adult height been reached?  Yes  No

Document the expected adult height goal: \_\_\_\_\_



## Genotropin<sup>®</sup> Prior Authorization Request Form (Page 4 of 4)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note:

This request may be denied unless all required information is received.

If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.

For urgent or expedited requests please call 1-800-711-4555.

This form may be used for non-urgent requests and faxed to 1-800-527-0531.