OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Norditropin® Prior Authorization Request Form (Page 1 of 4)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Growth hormone deficiency in adults
- ❑ Growth hormone deficiency in transition phase adolescents
- ❑ Idiopathic short stature (ISS)
- ❑ Isolated growth hormone deficiency in adults
- ❑ Noonan syndrome
- ❑ Pediatric growth failure associated with chronic renal insufficiency
- ❑ Pediatric growth hormone deficiency
- ❑ Prader-Willi syndrome
- ❑ Small for gestational age (SGA)
- ❑ Short-stature homeobox (SHOX) gene deficiency
- ❑ Turner syndrome
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the requested medication is prescribed by one of the following specialists:
❑ Endocrinologist ❑ Nephrologist (for patients with chronic renal insufficiency)

Select if the patient has history of trial and failure, contraindication or intolerance to the following:
❑ Genotropin ❑ Genotropin Miniquick ❑ Nutropin ❑ Nutropin AQ Pen ❑ Nutropin AQ Nuspin

For pediatric growth hormone deficiency, also answer the following:

Is the patient an infant less than 4 months of age? ❑ **Yes** ❑ **No**
Does the infant have growth deficiency? ❑ **Yes** ❑ **No**

Does the patient have a history of neonatal hypoglycemia associated with pituitary disease? ❑ **Yes** ❑ **No**

Does the patient have panhypopituitarism? ❑ **Yes** ❑ **No**

Select if the patient has pediatric growth hormone deficiency as confirmed by the following:

- ❑ Patient's height is greater than 2.0 standard deviations [SD] below mid-parental height (utilizing age and gender growth charts related to height)
- ❑ 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)
- ❑ Patient's growth velocity is greater than 2 SD below mean for age and gender
- ❑ Delayed skeletal maturation greater than 2 SD below mean for age and gender (e.g., delayed more than 2 years compared with chronological age)

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: _____

Norditropin® 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^2; less than or equal to 8 mcg/L if BMI is greater than or equal to 25 kg/m^2 and less than 30 kg/m^2; less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m^2
- ❑ 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
- ❑ Adrenocorticotropic hormone (ACTH)
- ❑ Thyroid stimulating hormone (TSH)
- ❑ 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
- ❑ Genetic mutations
- ❑ Irreversible structural hypothalamic-pituitary disease
- ❑ 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^2; less than or equal to 8 mcg/L if BMI is greater than or equal to 25 kg/m^2 and less than 30 kg/m^2; less than or equal to 4 mcg/L if BMI is greater than or equal to 30 kg/m^2
- ❑ 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**

Norditropin® 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 of 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 25th percentile for bone age? ❑ **Yes** ❑ **No**

Is there documentation that 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 3rd percentile for gestational age (more than 2 SD below population mean)
- ❑ Patient's birth **length** was below the 3rd percentile for gestational age (more than 2 SD below population mean)
- ❑ Patient's **height** remains less than or equal to the 3rd 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 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 5th 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: _____

Norditropin® 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?

_____

_____

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.