

Pharmacy Prior Approval Request for Growth Hormone – Children Less than 21 Years of Age

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
 3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
 7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
 11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days

Clinical Information

1. Diagnosis: _____
 FOR NON-PREFERRED DRUGS: COMPLETE THIS SECTION AS WELL AS BELOW.
 2. Failed two preferred drug(s). List preferred drugs failed: _____
 2b. Or list reason why patient cannot try two preferred drugs: _____
 3. History of: Turners Syndrome Prader Willi Syndrome Craniopharyngioma in the last 2 years
 Panhypopituitarism in the last 2 years Cranial Irradiation in the last 2 years
 MRI History of Hypopituitarism list: _____ Hypopituitarism
 Chronic Renal Insufficiency in the last 2 years SGA with IUGR
 Other: _____
 4. Please check all that apply:
 Patient has a height velocity < 25th Percentile for Bone Age. Height Velocity: _____
 Patient has low serum levels of IGF-1 and IGFBP-3 IGF-1 Level: _____ IGFBP-3 Level: _____
 Patient has other signs of hypopituitarism List: _____
 Patient is an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia
 Patient's height is < 3rd percentile for chronological age Height: _____ Percentile: _____
 Birth weight and/or length more than 2 standard deviations below mean for gestational age with no catch up by age 2.
 History of GHD in the last 2 years. Is there a genetic cause? _____
 Stim testing? Agent 1: _____ Agent 2: _____ Peak: _____ Ng/ml: _____
 5. Is the epiphysis open (if patient > 9 years old)? Yes No
 6. Is the patient diagnosed with unexplained short stature with height > 2.25 standard deviations below mean for age, and bone age >2 standard deviations below mean, and low serum levels of IGF-1 and IGFBP-3? Yes No IGF-1 Level: _____
 IGFBP-3 Level: _____
 7. Is the patient currently being treated? Yes No
 6a. Growth rate over previous year: _____ b. Has the patient entered puberty? Yes No
 8. Are IGF-1 and IGF-BP3 within age appropriate range? Yes No Results: _____
Zorbitive only: 9. Is there a history of short bowel syndrome in the last 2 years? Yes No
Increlex only: 10. Check all that apply:
 History of GH product in last year GH resistance is caused by mutation in GH receptor of post GH receptor signaling pathway
 Patient has IGF-1 gene defects GH gene deletions and patient has developed neutralizing antibodies to GH
 Patient ht < 3 SD < mean and IGF-1 level < 3 SD < Mean and normal or elevated GH levels.
Zorbitive only:
 11. Is there a history of short bowel syndrome in the last 2 years? Yes No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.