

PRIOR AUTHORIZATION REQUEST FORM
GROWTH HORMONE-ADULT

Genotropin[®], Humatrope[®], Norditropin[®], Nutropin AQ[®], Omnitrope[®] Saizen[®], Serostim[®], Zomacton[®], Zorbtive[®]

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: Norditropin[®] (somatropin), Nutropin AQ[®] (somatropin), Omnitrope[®] (somatropin)

Non-preferred: Genotropin[®] (somatropin), Humatrope[®] (somatropin), Saizen[®] (somatropin), Serostim[®] (somatropin), Zomacton[®] (somatropin), Zorbtive[®] (somatropin)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
GROWTH HORMONE DEFICIENCY IN ADULTS			
1. Does the member have the diagnosis of growth hormone deficiency in adults?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the ordering provider an endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a pituitary hormone deficiency (other than growth hormone) requiring hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a pituitary disease or a condition affecting the pituitary (e.g. pituitary tumor, surgical damage, hypothalamic disease, irradiation, trauma, panhypopituitarism, or infiltrative disease)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had a growth hormone provocative stimulation test with a measured peak level of <5 ng/mL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Does the member have 3 pituitary hormone deficiencies (other than growth hormone) that require replacement	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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therapy AND have an insulin-like growth factor (IGF-1) <80 ng/mL?			
SHORT BOWEL SYNDROME			
1. Does the member have the diagnosis of Short Bowel Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the provider a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member able to ingest solid food?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the member receiving parenteral nutrition at least 5 days/week to provide at least 3,000 calories per week?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the member meet with a nutritionist and documentation indicates that dietary needs and goals have been discussed?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)			
1. Does the member have the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) in adults?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an infectious disease specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member currently take antiretroviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a documented weight loss of at least 10% from baseline weight OR a body mass index (BMI) of <20?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had an adequate nutritional evaluation and has failed to respond to a high calorie intake diet?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show continued medical necessity and clinical efficacy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. For a diagnosis of AIDS, has the member demonstrated weight gain within the initial 12 weeks of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

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Physician Signature:

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Policy PHARM-027
Origination Date: 05/21/2016
Reviewed/Revised Date: 05/29/2020
Next Review Date: 05/29/2021
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