Prescriber Criteria Form

Growth Hormone 2024 PA Fax 101-A v1 010124.docx
Growth Hormone (GH)*
Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Zomacton (Somatropin)
*Serostim and Zorbtive are not approved for growth hormone deficiency
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Growth Hormone (GH)*.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of adult growth hormone deficiency? [If no, then skip to question 4.]	Yes	No
2	Does the patient meet ANY of the following: A) Failed 2 pre-treatment growth hormone (GH) stimulation tests, B) Failed 1 pre-treatment GH stimulation test AND had a pre-treatment insulin-like growth factor-1 (IGF-1) level more than 2 standard deviations below the mean? Note: Stimulation tests include: A) insulin tolerance test (ITT) (peak GH less than or equal to 5 ng/ml), B) Macrilen-stimulation test (peak GH level less than 2.8 ng/ml), C) glucagon-stimulation test (GST) (peak GH level less than or equal to 3 ng/ml) for pt with a body mass index (BMI) 25-30 kg/m2 and high pretest probability of growth hormone deficiency (GHD) (e.g., acquired structural abnormalities) or BMI less than 25 kg/m2, and D) GST (peak GH level less than or equal to 1 ng/ml) in pt with BMI 25-30 kg/m2 and low pretest probability of GHD or BMI greater than 30 kg/m2. [If yes, then skip to question 20.]	Yes	No
3	Does the patient have ANY of the following: A) Organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND a pre-treatment insulin-like growth factor-1 (IGF-1) level more than 2 standard deviations below the mean, B) Genetic or structural hypothalamic-pituitary defects, C) Childhood-onset growth hormone deficiency with	Yes	No

	congenital (genetic or structural) abnormality of the hypothalamus/pituitary/central nervous system? [If yes, then skip to question 20.] [If no, then no further questions.]		
4	Does the patient have a diagnosis of growth failure associated with chronic kidney disease (CKD)? [If yes, then skip to question 18.]	Yes	No
5	Does the patient have a diagnosis of pediatric growth hormone deficiency? [If no, then skip to question 9.]	Yes	No
6	Is the patient a neonate OR was the patient diagnosed with growth hormone deficiency as a neonate? [If yes, then skip to question 18.]	Yes	No
7	Does the patient meet ANY of the following conditions: A) Patient is younger than 2.5 years of age with a pre-treatment height more than 2 standard deviations below the mean and a slow growth velocity, B) Patient is 2.5 years of age or older with a pre-treatment 1 year height velocity more than 2 standard deviations below the mean OR a pre-treatment height more than 2 standard deviations below the mean plus a 1 year height velocity more than 1 standard deviation below the mean? [If no, then no further questions.]	Yes	No
8	Does the patient meet ANY of the following conditions: A) Patient has failed 2 pre-treatment growth hormone stimulation tests (peak level below 10 nanogram per milliliter), B) Patient has a pituitary or central nervous system disorder (e.g., genetic defect, acquired structural abnormality, congenital structural abnormality) AND a pre-treatment insulin-like growth factor-1 (IGF-1) level more than 2 standard deviations below the mean? [If yes, then skip to question 18.] [If no, then no further questions.]	Yes	No
9	Does the patient have a diagnosis of Noonan syndrome? [If yes, then skip to question 18.]	Yes	No
10	Does the patient have a diagnosis of idiopathic short stature? [If yes, then skip to question 18.]	Yes	No
11	Does the patient have a diagnosis of Prader-Willi syndrome? [If yes, then skip to question 18.]	Yes	No
12	Does the patient have a diagnosis of born small for gestational age (SGA)? [If no, then skip to question 14.]	Yes	No
13	Does the patient meet ALL of the following conditions: A) Patient is 2 years of age or older, B) Patient has a birth weight less than 2500 grams at gestational age more than 37 weeks OR a birth weight or length below the 3rd percentile for gestational age or at least 2 standard deviations below the mean for gestational age, C) Patient did not manifest catch-up growth by age 2?	Yes	No

	[If yes, then skip to question 18.] [If no, then no further questions.]		
14	Does the patient have a diagnosis of short stature homeobox-containing gene (SHOX) deficiency? [If yes, then skip to question 18.]	Yes	No
15	Does the patient have a diagnosis of Turner syndrome? [If no, then no further questions.]	Yes	No
16	Was the diagnosis confirmed by karyotyping? [If no, then no further questions.]	Yes	No
17	Is the patient's pre-treatment height less than the 5th percentile for their age? [If no, then no further questions.]	Yes	No
18	Does the patient have open epiphyses? [If no, then no further questions.]	Yes	No
19	Is the request for any of the following diagnoses: A) Pediatric growth hormone deficiency, B) Turner Syndrome, C) Patient born small for gestational age? [If no, then skip to question 22.]	Yes	No
20	Is the patient currently receiving the requested drug? [If no, then skip to question 22.]	Yes	No
21	Is the patient experiencing improvement of their condition with the requested drug? [If no, then no further questions.]	Yes	No
22	Is the requested drug being prescribed by or in consultation with any of the following specialists: A) Endocrinologist, B) Geneticist, C) Nephrologist, D) Infectious disease specialist, E) Gastroenterologist, F) Nutritional support specialist?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____