Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
Growth Hormones Medications Prior Authorization (PA)

Instructions:

This form is used by participating providers for coverage of **Growth Hormone Medications.** Please complete and fax this form back to Kaiser Permanente within 24 hours at fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Request will not be considered unless form is completely filled out.**

KP-MAS Formulary can be found at www.providers.kp.org/mas/formulary.html

A. Patient Information

Patient Name:	Kaiser ID (if available):
Patient Date of Birth:	Patient Phone Number:

B. Provider Information

Provider Name:	Provider NPI:
Provider Specialty:	
Provider Phone Number:	Provider Fax Number:
Provider address:	

Please check the box that applies:

☐ Standard Review (72 hours)

☐ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

C. Pharmacy Information

Pharmacy Name:	NABP/NPI #:
Pharmacy Phone Number:	Pharmacy Fax Number:

D. Drug Information

Drug Name and Strength:	Quantity and Days Supply:
Directions (SIG):	Date Requested:

E. For PEDIATRIC Patients (18 years of age and under) LENGTH OF AUTHORIZATION (pediatric): 1 Year

Note: New PA, complete all sections, except # 6; Renewal PA, complete #6; Sign and Fax the form.

1. Is the prescriber one of the following:
☐ Endocrinologist ☐ Nephrologist ☐ HIV Specialist
☐ Other

2. Does patient have open epiphysis?
☐ Yes, please go to question 4 ☐ No, please go to question 3

3. If patient has been previously diagnosed with growth hormone deficiency, has the patient been retested for growth hormone deficiency since completing his/her growth?
☐ Yes ☐ No

4. Has patient been diagnosed with one of the following:
☐ Turner Syndrome ☐ Prader-Willi Syndrome ☐ Renal Insufficiency
☐ Small for Gestational age (SGA) ☐ Idiopathic Short Stature ☐ Growth Hormone Deficiency (see requirements below under #5)
☐ Newborn with hypoglycemia and diagnosis of hypopituitarism or panhypopituitarism

5. **Requirements for Growth Hormone Deficiency**
☐ Documentation of growth velocity < 25th percentile for bone age in a child with no other identifiable cause and in whom hypothyroidism, chronic illness, under nutrition and genetic syndromes have been excluded
AND
☐ Documentation of growth hormone response of less than 10ng/ml to at least two provocative stimuli of growth hormone release: insulin, levodopa, Arginine, clonidine, or glucagon. Priming with sex steroids prior to stimulation test should be considered.

6. Requests for Renewal (pediatrics)

☐ Documentation of improved/normalized growth velocity. (Growth velocity has increased by at least 2 cm in the first year and is greater than 2.5 cm per year), AND has grown more than 1 inch in previous 12 months

AND

☐ Documentation of more than 1 standard deviation (2") below mid-parental height (unless parental height is diminished due to medical or nutritional reasons).

F. For ADULTS (>18 years of age) LENGTH OF AUTHORIZATION: 1 Year (Serostim® - 3 months)

Note: New PA, complete all sections, except # 7; Renewal PA, complete #7; Sign and Fax the form.

1. Is the prescriber an Endocrinologist?

☐ Yes ☐ No

2. Is there a diagnosis of growth hormone deficiency confirmed by growth hormone stimulation tests and rule-out of other hormonal deficiency, as follows: growth hormone response of fewer than five nanograms per mL to at least two provocative stimuli of growth hormone release: insulin, levodopa, L-Arginine, clonidine or glucagon when measured by polyclonal antibody (RIA) or fewer than 2.5 nanograms per mL when measured by monoclonal antibody (IRMA)

☐ Yes ☐ No

3. Is the cause of growth hormone deficiency a result of Adult Onset Growth Hormone Deficiency (AO-GHD) alone or with multiple hormone deficiencies, such as hypopituitarism, as a result of hypothalamic or pituitary disease, radiation therapy, surgery or trauma

☐ Yes ☐ No

4. Have other hormonal deficiencies, such as thyroid, cortisol or sex steroids been ruled out?

☐ Yes ☐ No

5. For **Zorbtive®** is there a diagnosis of short bowel syndrome?

☐ Yes ☐ No

6. For **Serostim®** only please complete questions below. Note: Length of Authorization is 3 months initial; then 1 year

a. Is there a diagnosis of AIDS Wasting or cachexia

☐ Yes ☐ No

b. Patient has a documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace® and Marinol®)

☐ Yes ☐ No

7. Requests for Renewal (adults)

☐ Documentation of response to therapy (improved body composition, reduced body fat, and increased lean body mass).

E. Addition Information

Is there any additional information that would help in the decision-making process? If so, please describe.

E. Provider Sign off

Provider Signature:	Date: