Health Partners Medicare

PRIOR AUTHORIZATION REQUEST FORM

Norditropin - Medicare

Phone: 215-991-4300 Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Medicare	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this request for a pediatric patient? If NO, go to 13.

☐ Yes ☐ No

Q2. Has the patient been diagnosed by an endocrinologist with growth failure due to growth hormone deficiency via clinical assessment of appropriate auxological findings documented and attached (such as growth chart, height, height velocity, chronological and bone age), AND at least one of the following (documentation must be attached): A) subnormal response to at least 2 provocative growth hormone (GH) stimulation tests (resulting in peak GH levels less than 10 ng/mL), OR B) subnormal response to at least one provocative GH stimulation test (resulting in peak GH level less than 10 ng/mL) AND subnormal insulin-like growth factor-1 (IGF-1) level, OR C) subnormal IGF-1 level AND panhypopituitarism (defined as deficiencies of at least 3 other pituitary hormones), pituitary disease, hypothalamic disease, hypothalamic/pituitary surgery, radiation therapy, or trauma. If YES, go to 6

☐ Yes ☐ No

Q3. Has the patient been diagnosed by an endocrinologist with short stature associated with any of the following syndromes: Noonan syndrome, Turner syndrome, Prader-Willi syndrome (PWS)? Is yes, please submit the following: A) appropriate genetic test to confirm specific syndrome diagnosed, and B) assessment of characteristic clinical manifestations consistent with the specific syndrome.

☐ Yes ☐ No

Q4. Has the patient been diagnosed by an endocrinologist with short stature due to being born small for gestational age (SGA) with no catch-up growth by age 2 to 4 years? If yes, please submit documentation of diagnosis?

☐ Yes ☐ No

Q5. Has the patient peen diagnosed by an endocrinologist with idiopathic short stature (ISS)? If yes, please submit the following: A) documentation of a height standard deviation score (SDS) less than -2.25 and associated with growth

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rates unlikely to allow one to reach normal adult height, and B) documentation of growth chart, growth potential, impaired height velocity for age group, and bone age.

☐ Yes ☐ No

Q6. Is this a renewal request?

☐ Yes ☐ No

Q7. Is there documentation of continued linear growth, linear potential remaining, and/or open epiphyses? If NO, go to 13.

☐ Yes ☐ No

Q8. Is there documentation that the patient has tolerated the medication?

☐ Yes ☐ No

Q9. Is documentation attached including the growth chart, height velocity, chronological age, bone age, and insulin-like growth factor-1 (IGF-1) level?

☐ Yes ☐ No

Q10. Given growth hormone therapy, is the patient's serum insulin-like growth factor-1 (IGF-1) concentration normal?

☐ Yes ☐ No

Q11. Is there a plan to increase or decrease the dose of growth hormone until the serum insulin-like growth factor-1 (IGF-1) concentration is normal?

☐ Yes ☐ No

Q12. Has the patient been diagnosed by an endocrinologist with adult growth hormone deficiency (GHD)?

☐ Yes ☐ No

Q13. Is the diagnosis of adult growth hormone deficiency (GHD) a result of childhood-onset GHD due to organic disease or as a result of panhypopituitarism, hypothalamic or pituitary surgery, hypothalamic or pituitary disease, radiation therapy, or trauma? If yes, please attach documentation.

☐ Yes ☐ No

Q14. Has the diagnosis of adult growth hormone deficiency (GHD) been confirmed with a subnormal serum insulin-like growth factor-1 (IGF-1) while off growth hormone or prior to starting growth hormone therapy? If yes, please attach documentation.

☐ Yes ☐ No

Q15. If the insulin-like growth factor-1 (IGF-1) value is questionable or uncertain, has adult growth hormone deficiency (GHD) been confirmed before replacement therapy is started, via a subnormal growth hormone response to provocative testing prior to or while off growth hormone therapy? If yes, please attach documentation.

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☐ Yes	☐ No
Q16. Is this a renewal request? ☐ Yes	☐ No
Q17. Is there documentation that the patient has tolerated the medication? ☐ Yes	☐ No
Q18. Given continued growth hormone therapy, is the patients serum insulin-like growth factor-1 (IGF-1) concentration normal? Please attach documentation of IGF-1. ☐ Yes	☐ No
Q19. Is there a plan to increase or decrease the dose of growth hormone until the serum insulin-like growth factor-1 (IGF-1) concentration is normal? If yes, please attach plan ☐ Yes	☐ No
Q20. Requested Duration: ☐ 12 Months	
Q21. Additional Information:	

_____ _____

Prescriber Signature Date

2023 Medicare Prior Authorization Request