## PEDIATRIC (<18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM



OptumRx P.O. Box 25184 Santa Ana, CA, 92799 Phone: (800) 310-6826 Fax: (866) 940-7328



Phone: (	800) 310-6826	Fax: (800) 940-/328	Community Plan
Notes This form would be a small start but	u		
Note: This form must be completed by t	•	•	
**All sections must	be completed	or the request wi	II be returned**
Patient's Medicaid #		Date of Birth	
Patient's Name		Prescriber's Name	
Prescriber's IN License #		Specialty	
Prescriber's NPI #		Prescriber's Signature	
Return Fax #		Return Phone #	
Check box if requesting retro-active PA		Date(s) of service re retro-active eligibility	
service 30 calendar days or less and going forwards	, 	osage	Treatment Duration
Requested Medication and Strength	D	osage	Treatment Duration
SOMATROPIN AGENTS – Initial Aut	horization		
Please select the member's diagnosis:			
☐ Growth hormone deficiency			
☐ Noonan syndrome (Norditropin only	y)		
☐ Prader-Willi syndrome		. f-:  /N t	O h.)
Renal function impairment associate	•	• •	
☐ Short-stature homeobox-containing	, gene (SHOA)	deliciency (Humati	ope or Zomacton only)
☐ Small for gestational age (SGA)			
☐ Turner syndrome			
<ul><li>☐ Other* (please provide diagnosis)_</li><li>☐ N/A</li></ul>			<del></del>
□ IV/A			
Diagnosis of Idiopathic short stature	es 🗌 No 🗌	N/A	
*The following decumentation will be	a required for	the shave diagna	oio*
<ul> <li>*The following documentation will b</li> <li>Confirmatory growth chart doc</li> </ul>	-	_	
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		0 standard deviation	<u> </u>
age		0 standard deviation	ns below population mean for given

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Please complete the following:

Current height: (inches)
Height 6 months prior:(inches)
Height 12 months prior:(inches)
Diagnosis of HIV-associated wasting or cachexia (Serostim only) $\square$ Yes $\square$ No $\square$ N/A
<ul> <li>*The following documentation will be required for the above diagnosis</li> <li>Quantitative measurement of lean body mass using DEXA (dual energy X-ray absorptiometry) or BIA (bioelectric impedance analysis)</li> <li>Documentation of involuntary weight loss of &gt;10% of baseline total body weight OR body cell mass &lt;30% for initial approval</li> </ul> Member's current AIDS/HIV anti-retroviral regimen:
Member has tried and failed the one other therapy for HIV-associated wasting or cachexia [e.g., anabolic steroids (include medication name, trial date, dose, frequency, duration, reason for failure)]
The following documentation will be required for any of the above diagnoses (except for HIV-associated
<ul> <li>wasting or cachexia indication being treated by Serostim):</li> <li>Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required</li> <li>Radiology report documenting a bone age of 14-15 or less in members assigned female at birth, 16-17 or less in members assigned male at birth</li> <li>Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)</li> </ul>
Please select one of the following for ALL indications:
<ul> <li>Request is for a preferred agent</li> <li>Request is for a non-preferred agent with a product-specific indication:</li> <li>List indication:</li> </ul>
Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:
*For ALL indications* – Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy   Yes  No  No  hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumore prior to initiating.
to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.
Prescriber Signature:

iease select or	ne of the following:					
	=		other than HIV-associ	ciated wasting or ca	chexia	
Pleas	Please select one of the following:					
L	Request is for a p	•				
L		non-preferred agent with a product-specific indication:  like to utilize a non-preferred agent over preferred agent based on the				
_	List indication:					
_	following medical		oreletted agent over p	Teleffed agent base	u on the	
	nchexia:	•	ired for diagnoses ot		_	
•	• • • • • • • • • • • • • • • • • • • •	ocumenting a bone embers assigned ma	age of 14-15 or less in	members assigned	female at birth,	
•	Radiology report do	ocumenting open ep	piphyses (NOTE: docu at puberty (estimate a			
The f	following documen	ntation will be requi	ired for idiopathic sh	ort stature diagnos	sis ONLY	
•	Growth rate of 2 to	2.5 cm/year or mor	e with growth hormone	e therapy 🗌 Yes 🏻	□ No	
ır		valid medical justific	eation for continued us	e:		
- *For ALL		han HIV-associate	d wasting or cachexi	<b>a</b> * Prescriber attests	•	
* <b>For ALL</b> continuing	indications other to monitor the mem transformation of sk	than HIV-associated	d wasting or cachexi tumor recurrence, proo	<b>a</b> * Prescriber attests	•	
* <b>For ALL</b> continuing malignant	indications other to monitor the mem transformation of sk	than HIV-associated	d wasting or cachexi tumor recurrence, prog riate	<b>a</b> * Prescriber attests gression of underlyir	ng disease, or	
*For ALL continuing malignant  Yes  I, member f	indications other to to monitor the memental transformation of sk  ■ No	chan HIV-associated nber for intracranial t kin lesions, if approp	d wasting or cachexi tumor recurrence, prog riate	a* Prescriber attests gression of underlying at I am continuing	ng disease, or to monitor the	
*For ALL continuing malignant  Yes  I, member f	indications other to to monitor the mem transformation of sk  No  No  for intracranial tumnation of skin lesion	than HIV-associated ober for intracranial to kin lesions, if approp nor recurrence, pro ns, if appropriate.	d wasting or cachexi tumor recurrence, prog riate hereby attest th	a* Prescriber attests gression of underlyir at I am continuing ng disease, or mali	ng disease, or to monitor the	
*For ALL continuing malignant     Yes  I, member f transform  Prescribe	indications other to to monitor the mem transformation of sk  No  for intracranial tumnation of skin lesioner Signature:	chan HIV-associated hber for intracranial to kin lesions, if approp nor recurrence, pro ns, if appropriate.	d wasting or cachexi tumor recurrence, prog riate hereby attest th gression of underlyin	a* Prescriber attests gression of underlyin at I am continuing ng disease, or mali	to monitor the gnant	
*For ALL continuing malignant     Yes  I, member f transform  Prescribe  Member h therapy	indications other to to monitor the mem transformation of sk  ☐ No  for intracranial tumnation of skin lesioner Signature:  ☐ nas a diagnosis of lesioners and the skin lesioner skin l	than HIV-associated has for intracranial to the contract of th	d wasting or cachexi tumor recurrence, prog riate hereby attest th gression of underlyin	a* Prescriber attests gression of underlyir at I am continuing ng disease, or mali	to monitor the gnant	
*For ALL continuing malignant  Yes  I,	indications other to to monitor the memoral transformation of skin lesion of skin	chan HIV-associated of the character of the character of the contract of the character of t	d wasting or cachexi tumor recurrence, progoriate hereby attest th gression of underlying sting or cachexia and	a* Prescriber attests gression of underlyir at I am continuing ng disease, or mali	to monitor the gnant	
*For ALL continuing malignant  Yes  I,	indications other to to monitor the mem transformation of sk  No  for intracranial tumnation of skin lesion of	chan HIV-associated ber for intracranial to kin lesions, if appropriate appropriate.  HIV-associated was DS/HIV anti-retrovirate an increase in ation required)	d wasting or cachexitumor recurrence, progriate hereby attest the gression of underlying sting or cachexia and all regimen:	a* Prescriber attests gression of underlyir at I am continuing ng disease, or mali d is continuing growt	to monitor the gnant  th hormone  th treatment	
*For ALL continuing malignant   Yes   I,	indications other to to monitor the memoral transformation of skin lesion of skin	chan HIV-associated of the contract of the con	d wasting or cachexitumor recurrence, progriate hereby attest the gression of underlying sting or cachexia and all regimen:n total body weight or	a* Prescriber attests gression of underlyir at I am continuing ng disease, or mali d is continuing growt	to monitor the gnant  th hormone  th treatment  wasting or	
*For ALL continuing malignant   Yes   I,	indications other to to monitor the mem transformation of skin lesion of skin les	chan HIV-associated ber for intracranial the form intracranial the first indicate the form intracranial the first indicate the first indicate the first interest in the first interest interest in the first interest interest in the first interest interest in the first interest interest interest in the first interest inter	d wasting or cachexitumor recurrence, progriate hereby attest the gression of underlying sting or cachexia and all regimen: n total body weight or ired for a diagnosis of the cachexia and the cachexia a	a* Prescriber attests gression of underlyin at I am continuing ng disease, or mali d is continuing growt lean body mass from	to monitor the gnant  th hormone  th reatment  vasting or  (lbs)	

INCRELEX (MECASERMIN) – Initial Authorization
Diagnosis of growth failure due to severe primary insulin-like growth factor-1 deficiency (primary IGFD) OR growth hormone (GH) gene deletion with acquired neutralizing antibodies to GH $\square$ Yes $\square$ No
Member is greater than or equal to 2 years of age and less than 18 years of age $\square$ Yes $\square$ No
*The following documentation will be required for the above diagnosis*
Radiology report documenting open epiphyses
Documentation of baseline height and weight
Please complete the following:
o Baseline height: (inches)
o Baseline weight:(kg or lb)
INIONELEY (MEGAGERANN). Documents of
INCRELEX (MECASERMIN) – Reauthorization
Member is less than 18 years of age ☐ Yes ☐ No
Improvement in annualized growth velocity (AGV) OR provider has submitted valid medical justification for continued use $\square$ Yes $\square$ No
Please complete the following:
o Current height: (inches)
Height 6 months prior:(inches)
o Height 12 months prior:(inches)
*The following documentation will be required for the above diagnosis*
Radiology report documenting open epiphyses
NGENLA (SOMATROGON-GHLA) – Initial Authorization
Diagnosis of growth failure due to growth hormone deficiency
Member is 3 years of age or older and less than 18 years of age $\ \square$ Yes $\ \square$ No
*The following documentation will be required for the above diagnosis*
<ul> <li>Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required</li> </ul>
Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
<ul> <li>Radiology report documenting open epiphyses (<u>NOTE:</u> documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))</li> </ul>
Previous trial and failure of Skytrofa (lonapegsomatropin) or Sogroya (somapacitan) $\ \square$ Yes $\ \square$ No
If yes, please provide chart documentation or dates of use
If no, please provide medical justification as to why Skytrofa (lonapegsomatropin) AND Sogroya (somapacitan) are unsuitable for use:

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy $\square$ Yes $\square$ No
I,hereby attest that I have performed all necessary testing
to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.
negatively impacted by growth normone therapy.
Prescriber Signature:
NGENLA (SOMATROGON-GHLA) – Reauthorization
<ul> <li>*The following documentation will be required for any of the indicated diagnoses*</li> <li>Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males</li> <li>Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))</li> </ul>
Member is less than 18 years of age $\square$ Yes $\square$ No
Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of
underlying disease, or malignant transformation of skin lesions, if appropriate $\square$ Yes $\square$ No
I,hereby attest that I continue to monitor the member for
intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin
lesions, if appropriate.
Prescriber Signature:
SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Initial Authorization
Diagnosis of growth failure due to growth hormone deficiency
Member is less than 18 years of age AND weighs 11.5 kg or greater ☐ Yes ☐ No ○ Weight: (kg or lb)
(g s:)
*The following documentation will be required for the above diagnosis*
Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required
<ul> <li>Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males</li> <li>Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is</li> </ul>
needed only if member is nearing or at puberty (estimate age range 10-17 years of age))
Trial and failure of at least ONE preferred somatropin product $\ \square$ Yes $\ \square$ No
If yes, please provide chart documentation or dates of use
·
<ul> <li>If yes, please provide chart documentation or dates of use</li> <li>If no, please provide medical justification as to why the available preferred somatropin agent(s) are</li> </ul>

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial
lesions or tumors prior to initiating growth hormone therapy $\ \square$ Yes $\ \square$ No
I,hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be
negatively impacted by growth hormone therapy.
Prescriber Signature:
SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Reauthorization
*The following documentation will be required for any of the indicated diagnoses*
Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males      Radiology report documenting appropriate and policy report appropriate and policy re
<ul> <li>Radiology report documenting open epiphyses (<u>NOTE:</u> documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))</li> </ul>
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Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of
underlying disease, or malignant transformation of skin lesions, if appropriate $\ \square$ Yes $\ \square$ No
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lesions, if appropriate.
Prescriber Signature:
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Tresoniser digitature.
SOGROYA (SOMAPACITAN) – Initial Authorization
SOGROYA (SOMAPACITAN) – Initial Authorization
SOGROYA (SOMAPACITAN) – Initial Authorization  Diagnosis of growth failure due to growth hormone deficiency  Yes No  Member is 2.5 years of age or older and less than 18 years of age Yes No
SOGROYA (SOMAPACITAN) – Initial Authorization  Diagnosis of growth failure due to growth hormone deficiency
SOGROYA (SOMAPACITAN) – Initial Authorization  Diagnosis of growth failure due to growth hormone deficiency  Yes No  Member is 2.5 years of age or older and less than 18 years of age Yes No  *The following documentation will be required for the above diagnosis*
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SOGROYA (SOMAPACITAN) – Initial Authorization  Diagnosis of growth failure due to growth hormone deficiency   Yes   No  Member is 2.5 years of age or older and less than 18 years of age  Yes   No  *The following documentation will be required for the above diagnosis*  Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))  Trial and failure of at least ONE preferred somatropin product  Yes  No  If yes, please provide chart documentation or dates of use
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SOGROYA (SOMAPACITAN) – Initial Authorization  Diagnosis of growth failure due to growth hormone deficiency   Yes   No  Member is 2.5 years of age or older and less than 18 years of age   Yes   No  *The following documentation will be required for the above diagnosis*  • Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required  • Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males  • Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))  Trial and failure of at least ONE preferred somatropin product   Yes   No  • If yes, please provide chart documentation or dates of use  • If no, please provide medical justification as to why the available preferred somatropin agent(s) are unsuitable for use:  Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy   Yes   No
SOGROYA (SOMAPACITAN) – Initial Authorization  Diagnosis of growth failure due to growth hormone deficiency   Yes   No  Member is 2.5 years of age or older and less than 18 years of age   Yes   No  *The following documentation will be required for the above diagnosis*  • Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required  • Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males  • Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))  Trial and failure of at least ONE preferred somatropin product  Yes  No  • If yes, please provide chart documentation or dates of use  No  • If no, please provide medical justification as to why the available preferred somatropin agent(s) are unsuitable for use:

Prescriber Signature:
SOGROYA (SOMAPACITAN) – Reauthorization
<ul> <li>*The following documentation will be required for any of the indicated diagnoses*</li> <li>Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males</li> <li>Radiology report documenting open epiphyses (<u>NOTE:</u> documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))</li> </ul>
Member is less than 18 years of age $\square$ Yes $\square$ No
Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate $\Box$ Yes $\Box$ No
I,hereby attest that I continue to monitor the member for
intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.
Prescriber Signature:
VOXZOGO (VOSORITIDE) – Initial Authorization
Diagnosis of achondroplasia ☐ Yes ☐ No
Member is less than 18 years of age $\square$ Yes $\square$ No
*The following documentation will be required for the above diagnosis*
<ul> <li>Radiology report documenting open epiphyses</li> <li>Documentation of baseline height and weight</li> </ul>
Please complete the following:
o Baseline height: (inches)
o Baseline weight:(kg or lb)
VOXZOGO (VOSORITIDE) – Reauthorization
Member is less than 18 years of age ☐ Yes ☐ No
Improvement in annualized growth velocity (AGV) of 1.5 cm/year OR provider has submitted valid medical justification for continued use $\Box$ Yes $\Box$ No
Please complete the following:
o Current height: (inches)
Height 6 months prior:(inches)
Height 12 months prior:(inches)
*The following documentation will be required for the above diagnosis*  • Radiology report documenting open epiphyses

## CONFIDENTIAL INFORMATION

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