Print Reset

United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Growth Hormone

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Is the Drug Prescribed by or in Consultation with a Specialist?

☐ Endocrinologist ☐ Nephrologist

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

CRITERIA

1. What is the diagnosis?
   - ☐ Idiopathic short stature (ISS)
   - ☐ Noonan syndrome (NS)
   - ☐ SHOX deficiency (SHOXD)
   - ☐ Adult GH deficiency
   - ☐ Prader Willi syndrome (PWS)
   - ☐ Chronic renal insufficiency
   - ☐ Other: _____
   - ☐ Pediatric growth hormone (GH) deficiency
   - ☐ Familial short stature
   - ☐ Small for gestational age (SGA)
   - ☐ Turner syndrome (TS)
   - ☐ Short bowel syndrome (SBS), ***skip to diagnosis section***
   - ☐ Pediatric chronic kidney disease, ***skip to diagnosis section***
2. Is this request for a new start, restart (re-initiation) or continuation of Growth Hormone (GH) therapy?
   ☐ New start, ***skip to diagnosis section*** ☐ Restart, ***skip to diagnosis section*** ☐ Continuation
3. Is the member's growth velocity at least 2 cm per year while on GH therapy?
   ☐ Yes ☐ No
   Action Required: *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*
4. Are the growth plates open?
   ☐ Yes ☐ No
5. What is the member's current height? Age: Years _____ Months _____ Height: _____ inches
   Action Required: *Please attach documentation from the medical record of current height.*

DIAGNOSIS AND MEDICAL INFORMATION

Complete the Following Section(s) Based on the Member's Diagnosis. Complete All That Apply:

Section A: All Pediatric Indications

6. What is the member's pretreatment height and age?
   Age: Years _____ Months _____ Height: _____ inches
   Action Required: *Please attach documentation from the medical record showing pretreatment height and age at measurement.*
7. Which of the following criteria does the member's pretreatment height meet?
   - ☐ Greater than or equal to 2.25 standard deviations (SD) below the mean for age and gender
   - ☐ Greater than or equal to 2 standard deviations (SD) below the mean for age and gender
8. What is the member's pretreatment growth velocity?
   - ☐ Greater than 1 standard deviation (SD) below the mean for age and gender
   - ☐ 1 SD below the mean for age and gender

   Action Required: *Please attach documentation from the medical record showing either.*
   - ☐ At least 2 heights measured by an endocrinologist at least 6 months apart (data for at least 1 year)
   - ☐ At least 4 heights measured by a primary care physician at least 6 months apart (data for at least 2 years)

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Section B: Pediatric GH Deficiency

9. Did the member have a GH response of less than 10 ng/mL (or otherwise abnormal as determined by the lab) of at least 2 GH stimulation tests?
   ☐ Yes ☐ No
   Action Required: *If YES, please attach documentation of stimulation test results.*
10. Did member have a GH response of less than 15 ng/mL on at least 1 GH stimulation test?
    ☐ Yes ☐ No
    Action Required: *Please attach documentation of GH stimulation test result. If YES, indicate results.*
11. Does the member have a defined CNS pathology, history of cranial irradiation or genetic condition associated GH deficiency?
    ☐ Yes ☐ No
12. Does the member have both IGF-1 and IGFBP-3 levels below normal for age and gender?
    ☐ Yes ☐ No
    Action Required: *If YES, please attach documentation from the medical record showing IGF-1 and IGFBP-3 levels below normal.*
13. Does the member have 2 or more documented pituitary hormone deficiencies other than GH?
    ☐ Yes ☐ No
14. Did the member have an abnormally low GH level in association with neonatal hypoglycemia?
    ☐ Yes ☐ No
    Action Required: *If YES, please attach documentation of GH level.*

Section C: Pediatric Chronic Kidney Disease/ Chronic Renal Insufficiencies

15. Does the member have any of the following? Indicate any/all the apply:
    ☐ Creatinine clearance of 75 mL/min/1.73 m2 or less ☐ Dialysis dependency
    ☐ Serum creatinine greater than 3.0 g/dL ☐ None of the above

Section D: Pediatric Chronic Kidney Disease

16. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?
    ☐ New start, *no further questions* ☐ Restart ☐ Continuation
17. Was GH therapy previously approved for this member?
    ☐ Yes ☐ No
18. What is the member's current height in inches? _____
    Action Required: *Please attach documentation from the medical record of current height.*
    If Restart, no further questions.
19. Is the member's growth velocity at least 2 cm per year while on GH therapy?
    ☐ Yes ☐ No
    Action Required: *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Section E: Adult GH Deficiency

20. Does the member have irreversible hypothalamic/pituitary structural lesions or ablation?
    ☐ Yes ☐ No ***If YES, no further questions.***
21. Does the member have a defect in GH synthesis?
    ☐ Yes ☐ No ***If YES, no further questions.***
22. Did the member have GH deficiency diagnosed during childhood?
    ☐ Yes ☐ No
23. Does the member have 3 or more pituitary hormone deficiencies?
    ☐ Yes ☐ No
24. Was the member retested for GH deficiency after an at least 1-month break in GH therapy?
    ☐ Yes ☐ No
25. Which of the following pharmacologic agents was used in a GH stimulation test to measure peak GH levels?
    ☐ Insulin ☐ Clonidine ☐ Levodopa ☐ Glucagon ☐ Arginine
    ☐ GH stimulation test not performed ☐ Other: _____
    Action Required: *Please attach documentation showing the results of GH stimulation test.*
26. Indicate the peak GH level: _____ ng/mL
27. Is the pretreatment IGF-1 level below the laboratory's range of normal?
    ☐ Yes ☐ No
    Action Required: *Please attach documentation from the medical record showing the member's pretreatment IGF-1 level.*

Section F: Short Bowel Syndrome

28. Is the member receiving specialized nutritional support?
    ☐ Yes ☐ No
29. Will GH be used in conjunction with optimal management of short bowel syndrome?
    ☐ Yes ☐ No
30. How many months of GH therapy has the member received? _____ months ☐ Not Applicable/New Start

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826