UnitedHealthcare Community Plan

# NC Pharmacy Prior Approval Request for
# Growth Hormone – Children Less than 21 Years of Age

## Beneficiary Information

1. Beneficiary Last Name: ____________________________ 2. First Name: ________________________________________
3. Beneficiary ID #: ____________________4. Beneficiary Date of Birth: ___________________ 5. Beneficiary Gender: ______

## Prescriber Information

6. Prescribing Provider NPI #: ________________________________________________________
7. Requester Contact Information - Name: _______________________________ Phone #: ______________________ Ext.__________

## Drug Information

8. Drug Name:_______________________________ 9. Strength: _________________ 10. Quantity Per 30 Days:__________
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

## Clinical Information

1. Diagnosis: ____________________
FOR NON-PREFERRED DRUGS: COMPLETE THIS SECTION AS WELL AS BELOW.
☐ Failed two preferred drug(s). List preferred drugs failed: ________________________________________________
Or list reason why patient cannot try two preferred drugs: ________________________________________________

2. History of: ☐ Turners Syndrome ☐ Prader Willi Syndrome ☐ Craniopharyngioma in the last 2 years
☐ Panhypopituitarism in the last 2 years ☐ Cranial Irradiation in the last 2 years
☐ MRI History of Hypopituitarism list: ___________ ☐ Hypopituitarism
☐ Chronic Renal Insufficiency in the last 2 years ☐ SGA with IUGR
☐ Other: ____________________________

3. Please check all that apply:
☐ Patient has a height velocity < 25th Percentile for Bone Age. Height Velocity: _____________________
☐ Patient has low serum levels of IGF-1 and IGFBP-3 IGF-1 Level: ________ IGFBP-3 Level: __________
☐ Patient has other signs of hypopituitarism List: ___________________________________
☐ Patient is an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia
☐ Patient's height is < 3rd percentile for chronological age Height: ___________ Percentile: ____________
☐ Birth weight and/or length more than 2 standard deviations below mean for gestational age with no catch up by age 2.
☐ History of GHD in the last 2 years. Is there a genetic cause? __________
Stim testing? Agent 1: ____ Agent 2: _____ Peak: _____ Ng/ml: ______

4. Is the epiphysis open (if patient > 9 years old)? ☐ **Yes** ☐ **No**
5. Is the patient diagnosed with unexplained short statue with height > 2.25 standard deviations below mean for age, and bone age >2 standard deviations below mean, and low serum levels of IGF-1 and IGFBP-3? ☐ **Yes** ☐ **No** IGF-1 Level: ______
IGFBP-3 Level: ______
6. Is the patient currently being treated? ☐ **Yes** ☐ **No**
6a. Growth rate over previous year: __________ b. Has the patient entered puberty? ☐ **Yes** ☐ **No**
7. Are IGF-1 and IGF-BP3 within age appropriate range? ☐ **Yes** ☐ **No** Results: __________________

**Zorbitive only**: 8. Is there a history of short bowel syndrome in the last 2 years? ☐ **Yes** ☐ **No**

**Increlex only**: 9. Check all that apply:
☐ History of GH product in last year ☐ GH resistance is caused by mutation in GH receptor of post GH receptor signaling pathway
☐ Patient has IGF-1 gene defects ☐ GH gene deletions and patient has developed neutralizing antibodies to GH
☐ Patient ht < 3 SD < mean and IGF-1 level < 3 SD < Mean and normal or elevated GH levels.

**Zorbitive only**:
14. Is there a history of short bowel syndrome in the last 2 years? ☐ **Yes** ☐ **No**

Signature of Prescriber:_______________________________________________ Date: _________________________
**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.