Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Growth Hormones Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations:
Initial- 1 year (Exception: Serostim: 3 months);

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Growth Hormones.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the provider either an Endocrinologist, Nephrologist, or has the provider consulted with one of these specialists prior to prescribing? □ No □ Yes

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

If requesting a non-preferred agent, please document why a preferred agent cannot be used:
_____

5 – Diagnosis

Pediatrics (≤ 18 years old) (select all that apply):

□ Turner Syndrome □ Prader-Willi Syndrome □ Pediatric Chronic Kidney Disease /Chronic Renal Insufficiency

□ Small for Gestational Age (SGA) □ Idiopathic Short Stature □ Growth Hormone (GH) Deficiency

□ Newborn with Hypoglycemia and Diagnosis of Hypopituitarism or Panhypopituitarism □ Familial Short stature

□ Pediatric growth hormone (GH) deficiency □ Noonan syndrome (NS) □ SHOX deficiency (SHOXD)

Adults (> 18 years old) (select all that apply):

□ Short Bowel Syndrome

□ AIDS Wasting or Cachexia

□ Primary Adult-Onset Growth Hormone Deficiency (AO-GHD)

□ Secondary Adult-Onset Growth Hormone Deficiency (AO-GHD) because of:

□ Hypothalamic or Pituitary Disease □ Radiation Therapy □ Surgery □ Trauma

6 – Clinical Criteria

Requirements for Pediatric Patients:

If the patient has closed epiphysis, has the patient been retested for GH deficiency since completing growth? □No □ Yes

Requirements for Growth Hormone Deficiency (select all that apply):

□ 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

□ GH response of < 10 ng/mL to ≥ 2 provocative stimuli of growth hormone release: insulin, levodopa, arginine, clonidine, or glucagon (priming with sex steroids prior to stimulation test should be considered)

Requirements for Pediatric Chronic Kidney Disease/Chronic Renal Insufficiencies

1. 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
2. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?
   □ New start, *no further questions* □ Restart*, refer to Q3 and Q4 below* □ Continuation, *refer to Continuation of therapy section below*
3. Was GH therapy previously approved for this member?
   □ Yes □ No
4. 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.

Requirements for Adult Patients:

Requirements for Growth Hormone Deficiency (select all that apply):

□ Rule-Out of other hormonal deficiencies (i.e. thyroid, cortisol, sex steroids) AND

□ GH response of < 5 ng/mL to ≥ 2 provocative stimuli of growth hormone release: insulin, levodopa, arginine, clonidine, or glucagon when measured by polyclonal antibody (RIA) OR < 2.5 ng/mL when measured by monoclonal antibody (IRMA)

Continuation of Therapy

Requirements for Pediatric Patients:

□ Documentation of improved/normalized growth velocity of at least 2 cm per year

Requirements for Adult Patients:

□ Documentation of prescriber affirmation of positive response to therapy

(i.e. improved body composition, reduced body fat, and increased lean body mass)

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**