



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)  
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)  
Growth Hormone (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.  
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Growth Hormone (Medicare Determination).

Drug Name(specify drug)

\_\_\_\_\_

**Patient Information**

Patient  
Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_  
Patient  
Group No.: \_\_\_\_\_  
Patient  
DOB: \_\_\_\_\_

**Prescribing Physician**

Physician  
Name: \_\_\_\_\_  
Physician  
Phone: \_\_\_\_\_  
Physician  
Fax: \_\_\_\_\_  
Physician  
Address: \_\_\_\_\_  
City, State,  
Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each applicable question.

- |                                                                                                                                                                                |   |   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services?                                                                                        | Y | N |
| 2. Does the patient have a diagnosis of HIV with wasting or cachexia?<br>[If the answer to this question is yes, then no further questions required.]                          | Y | N |
| 3. Does the patient have a diagnosis of short bowel syndrome?<br>[If the answer to this question is yes, then no further questions required.]                                  | Y | N |
| 4. Is the patient either less than 18 years of age, OR 18 years of age or older with open epiphyses?<br>[If the answer to this question is no, then skip to question 31.]      | Y | N |
| 5. Is the patient currently undergoing treatment with recombinant growth hormone (GH)?<br>[If the answer to this question is yes, then may skip to question 10.]               | Y | N |
| 6. Does the patient have a height that is more than 2 standard deviations below the mean for normal children of the same age (equivalent to less than 5th percentile for age)? | Y | N |
| 7. Does the patient have a predicted adult height that is more than 1.5 standard deviations below the mid-parental height?                                                     | Y | N |



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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|---|
| 8. Has the patient experienced a poor growth velocity defined as more than 1 standard deviation below the mean for normal children of the same age (less than 5 cm per year)?                                                                                                       | Y | N |
| 9. Will the physician evaluate the patient's serum insulin-like growth factor I (IGF-1) during the first three months of therapy to evaluate the dose?                                                                                                                              | Y | N |
| 10. Does the patient have closed or fused epiphyses?                                                                                                                                                                                                                                | Y | N |
| 11. Does the patient have the diagnosis of Turner syndrome?<br>[If the answer to this question is yes, then skip to question 25.]                                                                                                                                                   | Y | N |
| 12. Does the patient have the diagnosis of Prader-Willi Syndrome confirmed by appropriate genetic testing?<br>[If the answer to this question is no, then skip to question 16.]                                                                                                     | Y | N |
| 13. Is the patient severely obese?                                                                                                                                                                                                                                                  | Y | N |
| 14. Does the patient have a history of severe respiratory impairment or sleep apnea?                                                                                                                                                                                                | Y | N |
| 15. Will GH therapy be discontinued if the patient develops severe respiratory impairment while on therapy?<br>[May skip to question 25.]                                                                                                                                           | Y | N |
| 16. Does the patient have the diagnosis of chronic renal insufficiency or chronic renal failure?<br>[If the answer to this question is no, then skip to question 18.]                                                                                                               | Y | N |
| 17. Has the patient received a renal transplant?<br>[May skip to question 24.]                                                                                                                                                                                                      | Y | N |
| 18. At birth, was the patient small for gestational age (defined as more than two standard deviations below normal for height and weight)?<br>[If the answer to this question is no, then skip to question 20.]                                                                     | Y | N |
| 19. Did the patient demonstrate catch-up growth by age two?<br>[May skip to question 25.]                                                                                                                                                                                           | Y | N |
| 20. Does the patient have the diagnosis of Noonan syndrome?<br>[If the answer to this question is yes, then skip to question 25.]                                                                                                                                                   | Y | N |
| 21. Does the patient have the diagnosis of SHOX (short stature homeobox-containing gene) deficiency?<br>[If the answer to this question is yes, then skip to question 25.]                                                                                                          | Y | N |
| 22. Does the patient have a diagnosis of idiopathic short stature, for which diagnostic evaluation excludes other causes associated with short stature that should be observed or treated by other means?<br>[If the answer to this question is yes, then may skip to question 25.] | Y | N |
| 23. Prior to initiation of therapy, did the patient have a delayed bone age for chronological age?                                                                                                                                                                                  | Y | N |
| 24. Prior to initiation of therapy, had the patient failed at least two growth hormone (GH) stimulation tests? (Failure as defined by the individual stimulation test used.)                                                                                                        | Y | N |
| 25. Has the patient been evaluated for other causes of growth failure? [e.g., drug induced (e.g., steroids) skeletal disorders, malabsorption, chronic systemic disease, thyroid deficiency, celiac disease]                                                                        | Y | N |
| 26. Has the patient received at least 6 months of therapy through CVS Caremark pharmacy benefit?<br>[If the answer to this question is no, then no further questions required]                                                                                                      | Y | N |
| 27. Has the patient been evaluated for continuation of therapy (e.g., thyroid level, lipid level, body composition measurements and bone densitometry)?                                                                                                                             | Y | N |
| 28. Has height of the patient increased in the past 6 months?                                                                                                                                                                                                                       | Y | N |
| 29. Has the growth velocity of the patient improved since the initiation of growth hormone therapy?                                                                                                                                                                                 | Y | N |



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30. Has the physician evaluated the patient's serum insulin-like growth factor 1 (IGF-1) to confirm the appropriateness of continued therapy?  
[No further questions required.] Y N
31. Does the patient have a diagnosis of adult-onset hypothalamic-pituitary disease?  
[If the answer to this question is yes, then skip to question 33.] Y N
32. Does the patient have decreased hypothalamic-pituitary function due to any of the following?  
• pituitary tumor  
• pituitary surgical damage  
• trauma  
• cranial irradiation  
• documented structural lesions  
• proven genetic causes  
[If the answer to this question is no, then skip to question 35.] Y N
33. Does the patient have a documented deficiency of three or more pituitary hormones?  
[If the answer to this question is no, then skip to question 38.] Y N
34. Prior to the initiation of growth hormone therapy, does/did the patient have a normal insulin-like growth factor 1 (IGF-1) level?  
[May skip to question 41.] Y N
35. Does the patient have documented childhood-onset growth hormone deficiency? Y N
36. Does the patient have congenital/genetic growth hormone deficiency or multiple hormone deficiencies due to organic disease?  
[If the answer to this question is yes, then may skip to question 38.] Y N
37. Does the patient have a normal insulin-like growth factor 1 (IGF-1)?  
[If the answer to this question is yes, then may skip to question 39.] Y N
38. Has the patient failed one growth hormone (GH) stimulation test?  
[A failure is generally defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia.]  
[May skip to question 40.] Y N
39. Has the patient failed at least two growth hormone (GH) stimulation tests?  
[A failure is generally defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia.] Y N
40. Has the patient been assessed for other endocrine disorders (e.g., thyroid deficiency)? Y N
41. Will the physician evaluate the patient's serum insulin-like growth factor 1 (IGF-1) during the first 3 months of therapy to evaluate the dose? Y N
42. Has the patient received at least six months of therapy through a Caremark prescription benefit?  
[If the answer to this question is no, then no further questions required] Y N
43. Has the patient been monitored (e.g., thyroid level, lipid level, body composition measurements and bone densitometry) for continuation of therapy? Y N
44. Has the physician evaluated the patient's serum insulin-like growth factor 1 (IGF-1) to confirm the appropriateness of the dose? Y N
45. Has the patient had an improvement in symptoms (e.g., Y N



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decreased in body fat, increased bone density, better endurance, less fatigue) and clinical features of growth hormone deficiency?

**Comments:**

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I affirm that the information given on this form is true and accurate as of this date.

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**Prescriber (Or Authorized) Signature and Date**