01/19/2016

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Growth Hormone (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Growth Hormone (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (specify drug)

Quantity _____ Frequency _____ Strength _____
Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is growth hormone prescribed by a specialist based on the condition treated (e.g., endocrinologist, nephrologist)? List specialty here: Y N

   _____

   [If no, then no further questions.]

2. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If yes, skip to question 39.]

3. Does the patient have a diagnosis of idiopathic short stature? Y N

   [If yes, no further questions.]

4. Does the patient have any of the following: Untreated hypothyroidism / active proliferative diabetic retinopathy / severe nonproliferative diabetic retinopathy Y N

   [If yes, no further questions.]

5. Is this request for a child or adolescent with a diagnosis of growth hormone deficiency? Y N

   [If no, skip to question 10.]

6. Did the patient have an MRI or CT of the brain to exclude a tumor in the hypothalamic-pituitary region? Y N

   [If no, then no further questions]

7. Does the patient have growth hormone deficiency that is caused by a brain tumor and multiple pituitary hormone deficiency? Y N

   [If no, skip to question 9.]

8. Did the patient have a peak growth hormone level below 10 mcg/L on a fasting growth hormone stimulation test using at least one of the following provocative agents: arginine, glucagon, clonidine, insulin, propranolol, or levodopa? Please provide peak level and agent(s) tried: Y N

   _____

   [If no, then no further questions.]

   [If yes, skip to question 16]

9. Did the patient have peak growth hormone levels below 10 mcg/L on fasting growth hormone stimulation tests using 2 of the following provocative agents: arginine, glucagon, clonidine, insulin, propranolol, or levodopa? Please provide peak level and agent(s) tried: Y N

   _____

   [If no, then no further questions.]

   [If yes, skip to question 16]

10. Is this request for a child or adolescent with a diagnosis of Turner Syndrome or Prader-Willi Syndrome? Y N

    [If no, skip to question 12.]

11. Has the diagnosis been confirmed by genetic testing? Y N

    [If no, then no further questions.]

    [If yes, skip to question 18]

12. Is this request for a child or adolescent with a diagnosis of SHOX deficiency or Noonan Syndrome? Y N

    [If yes, skip to question 18.]

13. Is this request for a child or adolescent with a diagnosis of chronic kidney disease? Y N

    [If no, skip to question 21.]

14. Has the patient undergone a kidney transplant? Y N

    [If yes, no further questions.]

15. Have metabolic abnormalities (such as malnutrition, acidosis, secondary hyperparathyroidism and hyperphosphatemia) been corrected if they exist? Y N

    [If no, then no further questions.]

    [If yes, skip to question 18]

16. Does the patient have both a decreasing growth velocity AND a predisposing condition such as previous cranial irradiation or tumor? If yes, document patient's growth velocity and predisposing condition: Y N

    _____

    [If yes, skip to question 24]

17. Does the patient have another pituitary hormone deficiency or signs of congenital growth hormone deficiency (i.e., hypoglycemia, microphallus)? If yes, please provide documentation: Y N

    _____

    [If yes, skip to question 24]

18. Is the patient's height more than 3 standard deviations (SDS) below the mean for age and sex? If yes, document patient's height: Y N

_____

[If yes, skip to question 24]

19. Is the patient's height between 2 and 3 standard deviations (SDS) below the mean for age and sex AND growth velocity below the 25th percentile for age and sex? If yes, document patient's height and growth velocity: Y N

_____

[If yes, skip to question 24]

20. Is the patient's growth velocity measured over 1 year more than 2 standard deviations (SDS) below the mean for age and sex? If yes, document patient's growth velocity: Y N

_____

[If yes, skip to question 24]

[If no, then no further questions]

21. Does the patient have a diagnosis of small for gestational age (SGA) with failure to catch up by 2 to 4 years of age? Y N

[If no, skip to question 25.]

22. Is the patient's height 2 or more standard deviations below the mean for age and sex? Document height: Y N

_____

[If no, then no further questions.]

23. Was the patient's birth weight or length 2 or more standard deviations below the mean for gestational age (GA)? Document GA, birth weight and/or length: Y N

_____

[If no, then no further questions.]

24. Has the patient achieved adult height or have closed epiphyseal plates (growth plates)? Y N

[If yes, then no further questions]

[If no, skip to question 37]

25. Does the patient have a diagnosis of adult-onset growth hormone deficiency? Y N

[If no, skip to question 29.]

26. Is growth hormone deficiency due to a traumatic brain injury or subarachnoid hemorrhage? Y N

[If no, skip to question 28.]

27. Is this request for a child or adolescent with a diagnosis of chronic kidney disease? Y N

[If no, no further questions.]

[If yes, skip to question 32.]

28. Does the patient have a growth hormone deficiency due to an irreversible hypothalamic-pituitary structural lesion or panhypopituitarism AND a low serum IGF-1 level? If yes, provide cause of GH deficiency, IGF-1 level and date: Y N

[If yes, skip to question 36.]

[If no, skip to question 32]

29. Does the patient have a diagnosis of adult growth hormone deficiency of childhood-onset? Y N

[If no, then no further questions]

30. Was the patient retested for growth hormone deficiency 1-3 months after discontinuing growth hormone therapy to confirm the need to continue treatment in adulthood? Y N

[If yes, skip to question 32]

31. Does the patient have a growth hormone deficiency due to a known genetic mutation, congenital defect, an irreversible hypothalamic-pituitary structural lesion, or panhypopituitarism AND a low serum IGF-1 level? If yes, provide cause of GH deficiency, IGF-1 level and date: Y N

[If yes, skip to question 36.]

[If no, then no further questions.]

32. Did the patient have a baseline serum IGF-1 level drawn? Please provide baseline IGF-1 level and date drawn: Y N

[If no, no further questions.]

33. Does the patient have a serum IGF-1 level that is more than 2 standard deviations below the mean? Y N

[If yes, skip to question 35]

34. Does the patient have 2 growth hormone stimulation tests meeting one of the following? Please provide peak level and testing method: Y N

Insulin tolerance test showing peak growth hormone level was less than 5 mcg/L \ Stimulation using growth hormone releasing hormone, glucagon, or arginine showing a peak growth hormone level less than the laboratory normal for that agent

[If yes, skip to question 36]

[If no, then no further questions]

35. Does the patient have a growth hormone stimulation test meeting one of the following? Please provide peak level and testing method: Y N

Insulin tolerance test showing peak growth hormone level was less than 5 mcg/L \ Stimulation using growth hormone releasing hormone, glucagon, or arginine showing a peak growth hormone level less than the laboratory normal for that agent

[If no, then no further questions.]

36. Is the patient deficient for other pituitary hormone(s) that are not being treated? Y N

[If yes, then no further questions]

37. Is the requested medication a formulary preferred agent? Y N

[If yes, then no further questions]

38. Has the patient tried and failed the formulary preferred agent(s)? If yes, list medications tried and reason for failure: Y N

[No further questions]

39. Is the reauthorization request for a child or adolescent? Y N

[If no, skip to question 44.]

40. Is there any evidence of epiphyseal closure or that final height has been achieved? Y N

[If yes, no further questions.]

41. Is the patient's growth velocity greater than 5 cm/year OR less than 5 cm/yr but the dose will be increased? Please document current dose, height, weight, and growth velocity: Y N

[If no, then no further questions.]

42. Is the request for treatment of Prader-Willi Syndrome? Y N

[If no, then no further questions]

43. Has the patient had an improvement in body composition since starting growth hormone? Y N

[No further questions]

44. Is the patient responding to treatment as evidenced by an improvement in BMI, lipid panel, or bone density? Y N

[If no, then no further questions]

45. Is the patient's serum IGF-1 at a stable target range? Please document IGF-1 level and date drawn: Y N

[If yes, no further questions.]

46. Is the dose of growth hormone being adjusted to achieve target IGF-1? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date