9/01/2013

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS

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 at 1-855-684-5250.
Please contact Aetna Better Health Illinois 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).

Drug Name (select from list of drugs shown)

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: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is this request for renewal of therapy? Y N

   [If yes, skip to question 17.]

2. Initial Authorization Request - Child: Is the request for a child with one of the following diagnoses? Please document diagnosis: Y N

   _____

   Growth Hormone Deficiency (GHD) \ Turner Syndrome (TS) \ Prader-Willi Syndrome (PWS) \ SHOX deficiency\ Noonan Syndrome (NS) \ Chronic Renal Insufficiency (CRI) prior to renal transplant \ Small for gestational age (SGA) with failure to catch up growth by 4 years of age. NOTE: Growth hormone is contraindicated for patients with hypersensitivity to any of the product components, diabetic retinopathy, active neoplastic disease/malignancy, or acute critical illness/trauma (suspend use during acute critical illness/trauma). Growth hormone is not considered medically necessary for the diagnosis of Idiopathic Short Stature.

[If no (patient is an adult), skip to question 7 (For Initial Authorization Request - Adult)]

3. Is growth hormone prescribed by a pediatric endocrinologist? Y N

   [If no, no further questions.]

4. Does the patient have any of the following? Y N

   Closed epiphyses (e.g., bone age greater than 14 yrs, Tanner Stage 4-5) \ Untreated hypothyroidism, inadequate caloric intake/malnutrition/eating disorder, or other untreated condition that could be contributing to growth failure

   [If yes, no further questions.]

5. Has the following documentation based on diagnosis been submitted? Provider - please submit lab results. Y N

   GHD: underlying cause if known (eg, hypopituitarism, pituitary aplasia, septo-optic dysplasia, cranial surgery/irradiation, head trauma, CNS infection) and GH stim test result to 1 provocative agent. Note: Peak level must be below upper limit of normal (ULN) based on individual lab reference range \ IDIOPATHIC GHD: GH stim test results to 2 different provocative agents. Note: Peak levels must be below ULN based on individual lab reference range \ TS/PWS/SHOX DEFICIENCY/NS: karyotype studies/genetic studies \ CRI, PRE-TRANSPLANT: Recent serum creatinine and metabolic panel to support that any metabolic abnormalities identified have been corrected (eg, acidosis, hyperphosphatemia, hyperparathyroidism) \ SGA: Birth length or weight less than 3rd percentile for gestational age (GA), or birth weight of less than 2500g at GA of more than 37 weeks. PLEASE DOCUMENT GA AT BIRTH, BIRTH LENGTH, AND BIRTH WEIGHT:

   _____

   [If no, no further questions.]

6. Has the following baseline (within the last 3 months) documentation been submitted? PLEASE DOCUMENT HEIGHT, WEIGHT, PRETREATMENT GROWTH VELOCITY, AND DATES OF ASSESSMENT: Y N

   _____

   Height [Note: height should be more than 2 SDS below the mean (less than 3rd percentile) for age & sex] \ Weight \ Pretreatment growth velocity

   [No further questions]

7. Initial Authorization Request: Adult. Did patient have GHD as a CHILD, due to a known cause (e.g., hypopituitarism, pituitary aplasia, septo-optic dysplasia, cranial surgery or irradiation, head trauma, CNS infection)? IF YES, PLEASE DOCUMENT CONDITION: Y N

   _____

   *Note: For conditions other than GHD, such as Turner Syndrome, there is no proven benefit to continuing GH treatment into adulthood

once final height is achieved. Growth hormone is contraindicated for patients with hypersensitivity to any of the product components, diabetic retinopathy, active neoplastic disease/malignancy, or acute critical illness/trauma (suspend use during acute critical illness/trauma).

[If no, skip to question 9.]

8. Does patient have serum IGF-1 in target range? PLEASE DOCUMENT SERUM IGF-1 AND DATE DRAWN: Y N

_____

[If yes, no further questions.]

[If no, skip to question 20.]

9. Did patient have IDIOPATHIC GHD as a child? Y N

[If no, skip to question 12.]

10. Was patient retested for growth hormone deficiency 1-3 months after discontinuing growth hormone therapy? Y N

[If no, no further questions.]

11. Has the following documentation been submitted? Baseline serum IGF-1 and date drawn: Y N

_____

Growth hormone stimulation test results (Provider - please submit lab results): INSULIN TOLERANCE TEST (ITT) is considered the Gold Standard - peak less than or equal to half of the upper limit of normal based on individual lab reference range (1/2 of maximum normal value), OR ARGININE peak less than or equal to 0.4ng/ml. NOTE: LEVODOPA AND CLONIDINE TESTS ARE NOT RECOMMENDED

[No further questions]

12. Does patient have a diagnosis of ADULT-ONSET GHD due to traumatic brain injury or aneurysmal subarachnoid hemorrhage? Y N

[If no, skip to question 15.]

13. Has it been at least 12 months since the traumatic brain injury or aneurysmal subarachnoid hemorrhage? Y N

[If no, no further questions.]

14. Has the following documentation been submitted? Baseline serum IGF-1 and date drawn: _____ Y N

Growth hormone stimulation test results (Provider - please submit lab results): INSULIN TOLERANCE TEST (ITT) is considered the Gold Standard - peak less than or equal to half of the upper limit of normal based on individual lab reference range (1/2 of maximum normal value), OR ARGININE peak less than or equal to 0.4ng/ml NOTE: LEVODOPA AND CLONIDINE TESTS ARE NOT RECOMMENDED

[No further questions.]

15. Does patient have a diagnosis of ADULT-ONSET GHD due to a known cause (e.g., panhypopituitarism, cranial surgery or irradiation) Y N

    [If no, no further questions.]

16. Has the following documentation been submitted? BASELINE SERUM IGF-1 AND DATE DRAWN: _____ Y N

    [No further questions.]

17. Is the reauthorization request for a child? Y N

    [If no, skip to question 19.]

18. Has the patient met all of the following conditions for reauthorization? Y N

    Final height has not been achieved \ No evidence of epiphyseal closure, so linear growth is still possible \ Growth velocity is greater than 5cm/year on current dose, or growth velocity is less than 5cm/year but dose has been increased. Please document previous height, weight, and date AND current height, weight, and date: \ Review of the pharmacy claims history supports compliance.

    [No further questions.]

19. Is patient at target serum IGF-1 (i.e., at the middle for the age- and sex-appropriate reference range quoted by the laboratory used)? PLEASE DOCUMENT IGF-1 LEVEL AND DATE DRAWN: Y N

    _____

    [If yes, no further questions.]

20. 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