UnitedHealthcare Community Plan

Prior Authorization Request Form
Fax Back To: (866) 940-7328
Phone: (800) 310-6826

Specialty Medication Prior Authorization Cover Sheet

(This cover sheet should be submitted along with a Pharmacy Prior Authorization Medication Fax Request Form. Please refer to www.uhccommunityplan.com for medication fax request forms.)

Patient Information

Patient's Name:

Insurance ID: Date of Birth: Height: Weight:

Address: Apartment #:

City: State: Zip Code:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: Provider ID Number:

Address: City: State: Zip Code:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information

Medication: Quantity: ICD10 Code:

Directions: Diagnosis: Refills:

Physician Signature**: DAW (Initial here):

Physician Signature**: By signing above, the physician is providing the specialty pharmacy with a prescription that can be used to facilitate the dispensing and/or coordination of delivery for the requested medication.

Medication Instructions

Has the patient been instructed on how to **Self-Administer**? ☐ Yes ☐ No

Is this medication a **New Start**? ☐ Yes ☐ No

If **NO** please provide the following: Initiation Date: / / Date of Last Dose: / /

****Please attach any pertinent clinical information that would pertain to support stated diagnosis. Additional clinical information may be needed depending on your patients plan, including medication(s) previously tried and failed**

Delivery Instructions

Note: Delivery coordination requires a "**Physician Signature**" above and complete "**Provider Information**" and "**Patient Information**"

Note: All necessary ancillary supplies are provided free of charge to the patient at the time of delivery

Ship to: Physician's Office ☐ Patient's Address ☐ Date medication is needed: / /

Medication Administered: Home Health ☐ Self Administered ☐ LTC ☐ Physician's Office ☐

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Products - Washington

PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form contains multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quality:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

UnitedHealthcare Community Plan

Growth Hormone, Growth Stimulating Products - Washington
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information
(Refer to Section 11 for Reauthorization Requests)

1. All Requests *including Prader-Willi*

- What is the indication for this medication? (check all that apply)

□ Pediatric growth hormone deficiency
□ Growth failure in children small for gestational age (SGA)
□ Noonan syndrome
□ Short bowel syndrome
□ Pediatric growth failure with short-stature homeobox (SHOX) gene deficiency
□ Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
□ Prader-Willi syndrome
□ Turner syndrome (gonadal dysgenesis)
□ Adult growth hormone deficiency
□ Severe primary IGF-1 deficiency
□ Pediatric growth failure associated with chronic renal insufficiency
□ Other, List: _____

- If applicable, is the patient Tanner Stage 3 or greater? □ Yes □ No

- Has the patient been evaluated by one of the following:
□ Endocrinologist □ Nephrologist □ Neonatologist □ N/A

- Does the request include a current growth chart and results of all required diagnostic testing? □ Yes □ No (please attach documentation)

- What is the patient's bone age? _____ Date of Bone Age Study: _____

- Patient's BMI: _____

- Does the patient have open epiphyses? □ Yes □ No

- Has the patient demonstrated failure or intolerance to any of the preferred alternatives for the given diagnosis?
□ Yes □ No □ N/A (No preferred formulary alternatives available)
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
If no, list reason: _____

- If the requested medication is non-preferred, is there a reason or special circumstance that the patient must be treated with a non-preferred medication? □ Yes □ No
If yes, explain: _____

1. Requests for Pediatric Growth Hormone Deficiency

- Does the patient have one of the following diagnoses? □ Yes □ No (check which applies)
□ Less than 4 months of age with growth deficiency
□ History of neonatal hypoglycemia associated with pituitary disease
□ Panhypopituitarism
□ None of the above

- Is the patient's diagnosis confirmed by <u>one</u> of the following? □ Yes □ No (check which applies)
□ Projected height is > 2.0 standard deviations (SD) below mid-parental height
List height and SD below mid-parental height: _____
□ Height is > 2.25 SD below population mean
List height and SD below population mean: _____
□ Growth velocity is > 2 SD below mean
List growth velocity and SD below mean: _____
□ Delayed skeletal maturation of > 2 SD below mean
List skeletal maturation SD below mean: _____
□ None of the above

- Is one of the following below the age and gender adjusted normal range as provided by the physician's lab:
□ Insulin-like growth factor 1 (IGF-1/somatomedin-C) □ Insulin growth factor binding protein-3 (IGFBP-3)

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Member First name:	Member Last name:	Member DOB:

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has undergone <u>any</u> of the following provocative growth hormone (GH) stimulation tests: □ Yes □ No (check all that apply)

□ Arginine □ Clonidine □ Glucagon □ Insulin □ Levodopa □ Growth hormone releasing hormone

- List two Growth Hormone response values: _____ mcg/L _____ mcg/L

2. Requests for Growth Failure in Children Small for Gestational Age (SGA)

- Is the diagnosis based on demonstration of catch up growth failure in the first 24 months of life? □ Yes □ No

- Is there documentation that <u>one</u> of the following is ≥ 2 standard deviations (SD) below mean for gestational age? □ Yes □ No (If yes, fill in portion below)

□ Birth weight, List weight and SD below mean: _____

□ Birth length, List length and SD below mean: _____

□ None of the above

3. Requests for Turner Syndrome & Noonan Syndrome

- Does the patient meet <u>one</u> of the following: □ Yes □ No (check which applies)

□ Standing height > 3 standard deviations (SD) below mean
List standing height and SD below mean: _____

□ Standing height 2-3 SD below mean with deceleration of 2 heights measured by endocrinologist at least 6 months apart (≥1 year) or 4 heights measured by primary physician at least 6 months apart (≥2 years)
List all height and SD measurements: _____

□ Growth velocity of 2 SD below the mean over 1 year
List growth velocity, dates, and SD below mean: _____

□ None of the above

4. Requests for Short Stature Homeobox (SHOX) Gene Deficiency

- Does the patient have a diagnosis of pediatric growth failure with SHOX gene deficiency as confirmed by genetic testing? □ Yes □ No

5. Requests for Growth Failure Associated with Chronic Renal Insufficiency

- Does the patient have <u>one</u> of the following: □ Yes □ No

□ Structural or functional abnormalities of the kidney for ≥ 3 months
List dates: _____

□ GFR < 60 mL/min per 1.73m^2 for ≥ 3 months
List GFR and dates: _____

□ Occurrence of one each of the above together for any duration of time
List GFR and dates: _____

□ None of the above

6. Requests for Adult Growth Hormone Deficiency

- Are there clinical records supporting a diagnosis of childhood-onset growth hormone deficiency? □ Yes □ No

- Are there clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes? □ Yes □ No
If yes, list cause: _____

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting the patient has undergone <u>one</u> of the following GH stimulation tests to confirm adult GH deficiency: □ Yes □ No

□ Insulin tolerance test (ITT)
□ Glucagon
□ Arginine & GHRH (GHRH+ARG)
□ Arginine (ARG)

- Is there submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of any of the following anterior pituitary hormones: □ Yes □ No (check all that apply)

□ Prolactin
□ Thyroid stimulating hormone (TSH)
□ Adrenocorticotropic hormone (ACTH)
□ Follicle-stimulating hormone/luteinizing hormone (FSH/LH)

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Member First name:	Member Last name:	Member DOB:

- Did the test result in one of the following peak GH values: □ Yes □ No

□ ITT ≤ 5µg/L
□ Glucagon ≤ 3µg/L
□ GHRH+ARG
□ ARG ≤ 0.4µg/L
- If patient BMI < 25kg/m^2: ≤ 11µg/L
- If patient BMI ≥ 25kg/m^2 and <30kg/m^2: ≤ 8µg/L
- If patient BMI ≥ 30kg/m^2: ≤4µg/L

If yes, list test and result (and BMI if applicable): _____

- Is IGF-1/Somatomedin-C level below the age and gender adjusted normal range as provided by the physician's lab? □ Yes □ No If yes, list IGF-1/Somatomedin-C level and date: _____

- Does the patient have a diagnosis of panhypopituitarism? □ Yes □ No

- Will this be used in combination with any of the following: □ Yes □ No (check all that apply)

□ Aromatase inhibitors
□ Androgens

7. Requests for HIV-Associated Wasting/Cachexia

- Is there documentation of <u>one</u> of the following: □ Yes □ No (check which apply)

□ Unintentional weight loss >10% over the last 12 months
□ Loss of 5% body cell mass (BCM) within 6 months
□ Body mass index (BMI) < 20 kg/m^2

- List patient's weight: _____ kg/m^2 & Weight loss percentage: _____ %

- Has the patient's anti-retroviral therapy been optimized to decrease the viral load? □ Yes □ No

- Has the patient had weight loss as a result of other underlying treatable conditions? □ Yes □ No
List other conditions: _____

- Have treatment therapies other than growth hormone been suboptimal? □ Yes □ No (If yes, complete Section D above with medication information, including therapies, dates of trial, and reason for discontinuation)

- Has a nutritional evaluation has been completed since onset of wasting first occurred? □ Yes □ No
Date: _____

- Is this prescribed by or in consultation with a physician specializing in HIV diagnosis and management? □Yes□ No

8. Requests for Short Bowel Syndrome

- Is the patient currently receiving specialized nutritional support? □ Yes □ No

Physician Signature: _____ **Date:** _____