INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
PEDIATRIC (< 18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 866-930-0019

CareSource RxInnovations

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Member's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Member's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Member's Name	Prescriber's Name
Prescriber's Indiana License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's National Provider Identifier (NPI) # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Precriber Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber's Address _____ _____ _____	Date(s) of Service _____ Start Date _____
Diagnosis _____	Diagnosis Code _____

Requested Medication and Strength	Dosage	Treatment Duration

Prescriber Signature _____ **Date** _____

SOMATROPIN AGENTS – Initial Authorization

Please select the member's diagnosis:

- ☐ Growth hormone deficiency
- ☐ Noonan syndrome (Norditropin only)
- ☐ Prader-Willi syndrome
- ☐ Renal function impairment associated with growth failure (Nutropin AQ only)
- ☐ Short-stature homeobox-containing gene (SHOX) deficiency (Humatrope or Zomacton only)
- ☐ Small for gestational age (SGA)
- ☐ Turner syndrome
- ☐ Other* (please provide diagnosis) _____
- ☐ N/A

Diagnosis of Idiopathic short stature? ☐ Yes ☐ No ☐ N/A

The following documentation will be required for the above diagnosis

- Confirmatory growth chart documentation is required illustrating both of the following:
  - Height measurement of more than 2.0 standard deviations below population mean for given age
  - Growth rate of 5 cm/year or less prior to starting growth hormone therapy

Please complete the following:

Current: height: _____ (inches)

6 months prior: height: _____ (inches)

12 months prior: height: _____ (inches)

Diagnosis of HIV-associated wasting or cachexia (Serostim only)? ☐ Yes ☐ No ☐ N/A

***The following documentation will be required for the above diagnosis:**

- Quantitative measurement of lean body mass using DEXA (dual energy X-ray absorptiometry) or BIA (bioelectric impedance analysis)
- Documentation of involuntary weight loss from > 10% of baseline total body weight OR body cell mass < 30% for initial approval

Member's current AIDS/HIV anti-retroviral regimen: _____

Member has tried and failed the one other therapy for HIV-associated wasting or cachexia [e.g., anabolic steroids (include medication name, trial date, dose, frequency, duration, reason for failure)]:

_____

_____

The following documentation will be required for any of the above diagnoses (except for HIV-associated wasting or cachexia indication being treated by Serostim):

- Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required
- Radiology report documenting a bone age of 14-15 or less in members assigned female at birth, 16-17 or less in members assigned male at birth
- Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)

Please select one of the following for ALL indications:

☐ Request is for a preferred agent

☐ Request is for a non-preferred agent with a product-specific indication
List indication: _____

☐ Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:

_____

_____

For ALL indications – Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy? ☐ Yes ☐ No

I, _____, hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: _____

SOMATROPIN AGENTS – Reauthorization

Please select one of the following:

☐ Member has a diagnosis from initial authorization **other than** HIV-associated wasting or cachexia?

Please select one of the following:

- ☐ Request is for a preferred agent
- ☐ Request is for a non-preferred agent with a product-specific indication
  List indication: _____
- ☐ Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:

  _____

  _____

The following documentation will be required for diagnoses other than HIV-associated wasting or cachexia:

- Radiology report documenting a bone age of 14-15 or less in members assigned female at birth, 16-17 or less in members assigned male at birth
- Radiology report documenting open epiphyses (NOTE: documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)

The following documentation will be required for idiopathic short stature diagnosis ONLY

- Growth rate of 2 to 2.5 cm/year or more with growth hormone therapy? ☐ Yes ☐ No

  If **no**, please provide valid medical justification for continued use:

  _____

  _____

For ALL indications other than HIV-associated wasting or cachexia

Prescriber attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate?

☐ Yes ☐ No

If **no**, please provide valid medical justification for continued use:

_____

_____

I, _____, hereby attest that I am continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: _____

☐ Member has a **diagnosis of HIV-associated wasting or cachexia** and is continuing growth hormone therapy?

- Member's current AIDS/HIV anti-retroviral regimen: _____
- Member has demonstrated an increase in total body weight or lean body mass from treatment baseline **(documentation required)?** ☐ Yes ☐ No

The following documentation will be required for a diagnosis of HIV-associated wasting or cachexia:

Current:	height: _____ (inches)	weight: _____(lbs)
6 months prior:	height: _____ (inches)	weight: _____(lbs)
12 months prior:	height: _____ (inches)	weight: _____(lbs)

INCRELEX (MECASERMIN) – Initial Authorization

Diagnosis of growth failure due to severe primary insulin-like growth factor-1 deficiency (primary IGFD) OR growth hormone (GH) gene deletion with acquired neutralizing antibodies to GH? ☐ Yes ☐ No

Member is greater than or equal to two years of age and less than 18 years of age? ☐ Yes ☐ No

The following documentation will be required for the above diagnosis

- Radiology report documenting open epiphyses
- Documentation of baseline height and weight

Please complete the following:

- Baseline height: _____ (inches)
- Baseline weight: _____(kg or lb)

INCRELEX (MECASERMIN) – Reauthorization

Member is less than 18 years of age? ☐ Yes ☐ No

Improvement in annualized growth velocity (AGV) OR provider has submitted valid medical justification for continued use?
☐ Yes ☐ No

Please complete the following:

Current:	height: _____ (inches)
6 months prior:	height: _____ (inches)
12 months prior:	height: _____ (inches)

The following documentation will be required for the above diagnosis

- Radiology report documenting open epiphyses

NGENLA (SOMATROGON-GHLA) – Initial Authorization

Diagnosis of growth failure due to growth hormone deficiency? ☐ Yes ☐ No

Member is three years of age or older and less than 18 years of age? ☐ Yes ☐ No

The following documentation will be required for the above diagnosis

- Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required
- Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- Radiology report documenting open epiphyses [**NOTE:** documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)]

Previous trial and failure of Skytrofa (lonapegsomatropin) or Sogroya (somapacitan)? ☐ Yes ☐ No

- If yes, please provide chart documentation or dates of use: _____
- If no, please provide medical justification as to why Skytrofa (lonapegsomatropin) AND Sogroya (somapacitan) are unsuitable for use:

  _____

  _____

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy? ☐ Yes ☐ No

I, _____, hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.

Prescriber Signature: _____

NGENLA (SOMATROGON-GHLA) – Reauthorization

The following documentation will be required for any of the indicated diagnoses

- Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- Radiology report documenting open epiphyses [**NOTE:** Documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)]

Member is less than 18 years of age? ☐ Yes ☐ No

Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate? ☐ Yes ☐ No

I, _____, hereby attest that I continue to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: _____

SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Initial Authorization

Diagnosis of growth failure due to growth hormone deficiency ☐ Yes ☐ No

Member is less than 18 years of age AND weighs 11.5 kg or greater ☐ Yes ☐ No

- Weight: _____ (kg or lb)

The following documentation will be required for the above diagnosis

- Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required
- Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- Radiology report documenting open epiphyses [**NOTE:** Documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)]

Trial and failure of at least ONE preferred somatropin product? ☐ Yes ☐ No

- If yes, please provide chart documentation or dates of use: _____
- If no, please provide medical justification as to why the available preferred somatropin agent(s) are unsuitable for use:

  _____

  _____

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy? ☐ Yes ☐ No

I, _____, hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.

Prescriber Signature: _____

SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Reauthorization

The following documentation will be required for any of the indicated diagnoses

- Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- Radiology report documenting open epiphyses [**NOTE:** Documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)]

Member is less than 18 years of age? □ Yes □ No

Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate? □ Yes □ No

I, _____, hereby attest that I continue to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: _____

SOGROYA (SOMAPACITAN) – Initial Authorization

Diagnosis of growth failure due to growth hormone deficiency □ Yes □ No

Member is 2.5 years of age or older and less than 18 years of age □ Yes □ No

The following documentation will be required for the above diagnosis

- Documentation of biochemical evidence or other applicable testing supporting the diagnosis is required
- Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- Radiology report documenting open epiphyses [**NOTE:** Documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)]

Trial and failure of at least ONE preferred somatropin product? □ Yes □ No

- If yes, please provide chart documentation or dates of use: _____
- If no, please provide medical justification as to why the available preferred somatropin agent(s) are unsuitable for use:

  _____

  _____

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy? □ Yes □ No

I, _____, hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.

Prescriber Signature: _____

SOGROYA (SOMAPACITAN) – Reauthorization

The following documentation will be required for any of the indicated diagnoses

- Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- Radiology report documenting open epiphyses [**NOTE:** Documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age)]

Member is less than 18 years of age? ☐ Yes ☐ No

Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate? ☐ Yes ☐ No

I, _____, hereby attest that I will continue to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: _____

VOXZOGO (VOSORITIDE) – Initial Authorization

Diagnosis of achondroplasia? ☐ Yes ☐ No

Member is less than 18 years of age? ☐ Yes ☐ No

The following documentation will be required for the above diagnosis

- Radiology report documenting open epiphyses
- Documentation of baseline height and weight

Please complete the following:

- Baseline height: _____ (inches)
- Baseline weight: _____(kg or lb)

VOXZOGO (VOSORITIDE) – Reauthorization

Member is less than 18 years of age? ☐ Yes ☐ No

Improvement in annualized growth velocity (AGV) of 1.5 cm/year OR provider has submitted valid medical justification for continued use? ☐ Yes ☐ No

Please complete the following:

Current: height: _____ (inches)

6 months prior: height: _____ (inches)

12 months prior: height: _____ (inches)

The following documentation will be required for the above diagnosis

- Radiology report documenting open epiphyses