

**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

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****

Patient's CareSource # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name
Prescriber's Indiana License # <input type="text"/>	Specialty
Prescriber's National Provider Identifier (NPI) #: <input type="text"/>	Office Contact
Return Fax # <input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone # <input type="text"/> - <input type="text"/> - <input type="text"/>
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)

Height six months prior: _____ (inches)

Height 12 months prior: _____ (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 dual energy X-ray absorptiometry (DEXA) or bioelectric impedance analysis (BIA)
- Documentation of involuntary weight loss of > 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

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)

Three months prior: height: _____ (inches) weight: _____ (lbs)

Six 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)
- Height six months prior: _____ (inches)
- Height 12 months prior: _____ (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) Yes No

- If yes, please provide chart documentation or dates of use _____
- If no, please provide medical justification as to why Skytrofa (lonapegsomatropin) is 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 (LONAPEG SOMATROPIN-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 (LONAPEG SOMATROPIN-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)]**

Previous trial and failure of Skytrofa (lonapegsomatropin) Yes No

- If yes, please provide chart documentation or dates of use _____
- If no, please provide medical justification as to why Skytrofa (lonapegsomatropin) is 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 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)
- Height six months prior: _____ (inches)
- Height 12 months prior: _____ (inches)

The following documentation will be required for the above diagnosis

- Radiology report documenting open epiphyses

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.