aetna®

Adult Growth Hormone Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____

Medicaid: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ Endocrinologist ☐ Internist ☐ Other: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____

Name: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION (Please refer to Clinical Policy Bulletin # 0170 for formulary information for non-Medicare members)

Request is for: ☐ Genotropin ☐ Humatrope ☐ Norditropin ☐ Nutropin ☐ Omnitrope
☐ Saizen ☐ Serostim ☐ Zomacton ☐ Zorbtive
***Dose:** _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification request.

Please provide the following: Height (cm): _____ Weight(kg): _____ *Date:* ____/____/____

For Growth Hormone Deficiency in Adults:

☐ Yes ☐ No Does the patient have a documented contraindication or intolerance to Omnitrope? *If yes, clinical documentation must be submitted for review.*

***Destructive lesions of the pituitary**:*

☐ Yes ☐ No Does the patient have a Growth Hormone deficiency as a result of hypothalamic or pituitary disease (e.g., panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery)?

☐ Yes ☐ No Does the patient have at least one other hormone deficiency diagnosed (except for prolactin deficiency)?
If yes, please list the other hormone deficiency: _____

☐ Yes ☐ No Is the patient receiving replacement therapy for any other pituitary hormone deficiencies?
If yes, please list the replacement therapy: _____

***Adults who were Growth Hormone (GH) deficient as children or adolescents**:*

☐ Yes ☐ No Is the patient 24 years of age or younger?

☐ Yes ☐ No Does the patient have childhood-onset GH deficiency (including idiopathic isolated growth hormone deficiency (IIGHD) or multiple pituitary hormone deficiencies, including growth hormone (MPHD))?

☐ Yes ☐ No Has the patient completed linear growth (growth rate less than 2 cm per year)? (clinical documentation required for evaluation)

→ *If yes,* ☐ Yes ☐ No Has the patient stopped GH treatment for at least 3 months after completion of linear growth (i.e., growth rate less than 2 cm/year) and prior to initiating GH supplementation at an adult dose?
If yes, please enter the date GH therapy stopped _____

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(Please return **Pages 1 and 2** for precertification of medications.)

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)*

Adults who develop Growth Hormone (GH) deficiency in early adulthood:

☐ Yes ☐ No Does the patient have GH deficiency (including idiopathic isolated growth hormone deficiency (IIGHD) or multiple pituitary hormone deficiencies, including growth hormone (MPHD)) in adolescence or early adulthood that has completed linear growth (growth rate less than 2 cm per year) before the age of 25 yrs?

☐ Yes ☐ No Has the patient reached peak bone mass?

For Destructive lesions of the pituitary, Adults who were Growth Hormone (GH) deficient as children, or adolescents, or early adulthood:

What is the patient's IGF-1 (a marker of insulin response) concentration? _____

What is the patient's GH Deficiency Quality of Life Assessment (QoL-AGHDA) score? _____

☐ Yes ☐ No Has the patient failed to respond to standard GH stimulation tests, defined as a peak GH response of less than 9 mU/liter (3 ng/ml) during an insulin tolerance test and one other cross-validated GH test (growth hormone releasing hormone, arginine, or glucagon)? *Enter all tests below*

1st GH stimulation *Agent* _____ Date test taken: _____ Serum GH peak level(ng/ml) _____

2nd GH stimulation *Agent* _____ Date test taken: _____ Serum GH peak level(ng/ml) _____

***AIDS-related wasting**:*

What is the patient's pre-illness baseline body weight? _____

What is the patient's current weight? _____

What is the patient's body mass index (BMI)? _____

☐ Yes ☐ No Is the patient diagnosed with HIV?

☐ Yes ☐ No Is the patient's weight loss involuntary?

☐ Yes ☐ No Are there any other conditions that would explain the involuntary weight loss or a BMI less than 20 kg/m2?

☐ Yes ☐ No Has the patient failed to adequately respond or is intolerant to anabolic steroids (e.g., Megace)?

***Short Bowel Syndrome**:*

☐ Yes ☐ No Is the patient diagnosed with short bowel syndrome?

☐ Yes ☐ No Is the patient dependent on intravenous parenteral nutrition for nutritional support?

☐ Yes ☐ No Has the patient been treated with GH for short bowel syndrome in the past?

→ *If yes,* how many weeks was the patient treated with GH for short bowel syndrome? _____ or enter dates treated _____

***For Continuation**:*

☐ Yes ☐ No Has the patient had continuous follow-ups and re-evaluations of care to ensure patient compliance with therapy?

☐ Yes ☐ No Is the patient responding adequately to Growth Hormone therapy?

Please attach patient progress notes, history, and examination documentation to support the continuation of therapy.

H. Growth Hormone Deficiency Assessment (QoL - AGHDA)

Please Indicate Yes *or* No whether each of the following statements below applies.

☐ Yes ☐ No Have to struggle to finish jobs
☐ Yes ☐ No Feel a strong need to sleep during the day
☐ Yes ☐ No Often feel lonely even when I am with other people
☐ Yes ☐ No Have to read things several times before they sink in
☐ Yes ☐ No Have difficulty making friends
☐ Yes ☐ No It takes a lot of effort for me to do simple tasks
☐ Yes ☐ No Have difficulty controlling my emotions
☐ Yes ☐ No Often lose track of what I want to say
☐ Yes ☐ No Lacking in confidence
☐ Yes ☐ No Have to push myself to do things
☐ Yes ☐ No Often feel very tense
☐ Yes ☐ No Feel as if I let people down
☐ Yes ☐ No Find it hard to mix with people
☐ Yes ☐ No Feel worn out even when I've not done anything
☐ Yes ☐ No There are times when I feel very low
☐ Yes ☐ No Avoid responsibility if possible
☐ Yes ☐ No Avoid mixing with people I don't know
☐ Yes ☐ No Feel as if I am a burden to people
☐ Yes ☐ No Often forget what people have said to me
☐ Yes ☐ No Find it difficult to plan ahead
☐ Yes ☐ No Easily irritated by other people
☐ Yes ☐ No Often feel too tired to do the things I ought to do
☐ Yes ☐ No Have to force myself to do all the things that need doing
☐ Yes ☐ No Often have to force myself to stay awake
☐ Yes ☐ No Memory lets me down

I. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.