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Pediatric Growth Hormone Injectable Medication Precertification Request

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

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:	

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 ☐ 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: Decimal Age: _____ Current Height (cm): _____ Current Weight(kg): _____ *Date:* ____/____/____
Growth Velocity (GV)_____ Prior Year Height (cm): _____ Prior Year Weight(kg): _____ *Date:* ____/____/____

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

Requests for Growth Hormone deficiency in children and adolescents:

☐ Yes ☐ No Has the patient been diagnosed with **idiopathic growth hormone deficiency (GHD)**?
If yes, please answer the following:
☐ Yes ☐ No Has the patient failed to respond to at least two standard GH stimulation tests?
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) _____
☐ Yes ☐ No Is there documentation of normal thyroid function (TSH) at the time of GH stimulation testing?
TSH results:_____ Date test taken: _____
☐ Yes ☐ No Does the patient have defined CNS pathology, history of irradiation, multiple pituitary hormone deficiency (MPHD) or a genetic defect affecting the GH axis?
☐ Yes ☐ No Has the patient had appropriate imaging (magnetic resonance imaging (MRI) or computed tomography (CT)) of the brain with particular attention to the hypothalamic-pituitary region which excludes the possibility of a tumor?
MRI or CT Date: _____

☐ Yes ☐ No Has the patient been diagnosed with **chronic renal insufficiency and growth retardation**?
If yes, please answer the following:
☐ Yes ☐ No Has the patient had a renal transplant? *If yes*, please enter the date of the renal transplant? _____
☐ Yes ☐ No Has the patient's nutritional status been optimized?
☐ Yes ☐ No Has the patient's metabolic abnormalities been corrected?
☐ Yes ☐ No Has the patient's steroid usage been reduced to a minimum?

☐ Yes ☐ No Has the patient been diagnosed with **Turner's syndrome**?
If yes, please answer the following:
☐ Yes ☐ No Has the patient's diagnosis of Turner's syndrome been confirmed by chromosome analysis?

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(Continued)*

☐ Yes ☐ No Has the patient been diagnosed with **Prader Willi syndrome**?

If yes, please answer the following:

☐ Yes ☐ No Has the patient's diagnosis of Prader Willi syndrome been confirmed by appropriate genetic testing?

For Idiopathic Growth Hormone Deficiency:
Select all applicable criteria in questions 1-5 below for Chronic Renal Insufficiency
Select all applicable criteria in questions 1-3 for Turner's Syndrome, Prader Willi Syndrome

☐ Yes ☐ No Has the patient had at least one of the following criteria:

Please check ALL that apply

☐ 1. Child has severe growth retardation with height standard deviation score (SDS) more than 3 SDS below the mean for chronological age and sex.

☐ 2. Child has moderate growth retardation with height SDS between -2 and -3 SDS below the mean for chronological age and sex and decreased growth rate (growth velocity (GV) measured over 1 year below 25th percentile for age and sex).

☐ 3. Child exhibits severe deceleration in growth rate (GV) measured over 1 year -2 SDS below the mean for age and sex).

☐ 4. Child has decreasing growth rate combined with a predisposing condition such as previous cranial irradiation or tumor.

☐ 5. Child exhibits evidence of other pituitary hormone deficiencies or signs of congenital GHD (hypoglycemia, microphallus).

☐ Yes ☐ No Has the patient been diagnosed as **small for gestational age (SGA)**?

If yes, please answer the following:

Please provide the patient's birth weight, length, and gestational age: _____

Please provide the patient's current height and date taken: _____

☐ Yes ☐ No Is the birth weight or length two or more standard deviations below the mean for gestational age?

☐ Yes ☐ No Does the patient fail to manifest catch up growth by age of 2 years old, defined as height two or more standard deviations below the mean for age and sex?

Note: Growth curves plotting growth from birth through age 3 should be submitted for evaluation.

☐ Yes ☐ No Has the patient been diagnosed with **prepubertal short stature associated with Noonan syndrome**?

If yes, please answer the following:

☐ Yes ☐ No Does the patient have a height of two or more standard deviations below the mean for chronological age and sex?

☐ Yes ☐ No Has the patient had their GV measured over one year prior to initiation of therapy, with one or more standard deviations below the mean for age and sex?

NOTE: Clinical documentation must be submitted for evaluation

☐ Yes ☐ No Has the patient been diagnosed with **Short Stature Homeobox-Containing Gene (SHOX) Deficiency**?

If yes, please answer the following:

☐ Yes ☐ No Does the radiological report indicate the patient's epiphyses are closed? (clinical documentation must be submitted for evaluation)

For Continuation of Therapy:

How long has patient been on growth hormone therapy?

☐ 6-12 months ☐ 1year or more Please provide the date range: _____

Please provide the height velocity growth (in centimeters) achieved during the previous 12 months of therapy. _____ cm

Please provide the percentage of growth velocity from baseline during the 1st year of therapy? _____%

☐ Yes ☐ No Has final adult height been reached?

☐ Yes ☐ No Have there been any persistent and uncorrectable problems with adherence to treatment?

☐ Yes ☐ No **For Prader Willi syndrome:** Has body composition (i.e., ratio of lean to fat mass) significantly improved?

If yes, please provide the lean to fat mass ratio? _____

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

H. 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.