Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Growth Hormones Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year (Exception: Serostim: 3 months); Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Growth Hormones.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the provider either an Endocrinologist, Nephrologist, HIV Specialist, or has the provider consulted with one of these specialists prior to prescribing? □ No □ Yes

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

□Initial Request □ Continuation of Therapy Request

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5 – Diagnosis

Pediatrics (≤ 18 years old) (select all that apply):

□ Turner Syndrome □ Prader-Willi Syndrome □ Renal Insufficiency
□ Small for Gestational Age (SGA) □ Idiopathic Short Stature □ Growth Hormone (GH) Deficiency
□ Newborn with Hypoglycemia and Diagnosis of Hypopituitarism or Panhypopituitarism

Adults (> 18 years old) (select all that apply):

□ Short Bowel Syndrome (Required for Zorbtive)
□ AIDS Wasting or Cachexia (Required for Serostim)
□ Primary Adult Onset Growth Hormone Deficiency (AO-GHD)
□ Secondary Adult Onset Growth Hormone Deficiency (AO-GHD) because of:
□ Hypothalamic or Pituitary Disease □ Radiation Therapy □ Surgery □ Trauma

6 – Clinical Criteria

Initial Therapy

Requirements for Pediatric Patients:
If the patient has closed epiphysis, has the patient been retested for GH deficiency since completing growth? □No □ Yes

Requirements for Growth Hormone Deficiency (select all that apply):
□ Growth velocity < 25th percentile for bone age in a child with no other identifiable cause and in whom hypothyroidism, chronic illness, under nutrition and genetic syndromes have been excluded
AND
□ GH response of < 10 ng/mL to ≥ 2 provocative stimuli of growth hormone release: insulin, levodopa, arginine, clonidine, or glucagon (priming with sex steroids prior to stimulation test should be considered)

Requirements for Adult Patients:
Requirements for Growth Hormone Deficiency (select all that apply):
□ Rule-Out of other hormonal deficiencies (i.e. thyroid, cortisol, sex steroids) AND
□ GH response of < 5 ng/mL to ≥ 2 provocative stimuli of growth hormone release: insulin, levodopa, arginine, clonidine, or glucagon when measured by polyclonal antibody (RIA) OR < 2.5 ng/mL when measured by monoclonal antibody (IRMA)

Continuation of Therapy

Requirements for Pediatric Patients:
□ Documentation of improved/normalized growth velocity of at least 2 cm per year

Requirements for Adult Patients:
□ Documentation of prescriber affirmation of positive response to therapy
(i.e. improved body composition, reduced body fat, and increased lean body mass)

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**