FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR GROWTH HORMONE DRUGS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Completion Instructions, F-11092A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Does the member have a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) wasting disease or cachexia? (Complete Section IIIB only if yes is checked.) ❑ Yes ❑ No

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (Except for Serostim or Zorbtive.)

15. Is the drug requested a preferred growth hormone drug? ❑ Yes ❑ No

If the drug is a non-preferred growth hormone drug, describe the reason for the request in the space provided.

16. Is the member 17 years of age or younger? ❑ Yes ❑ No

17. Is the prescription for the growth hormone drug written by an endocrinologist? ❑ Yes ❑ No

Continued

SECTION IIIA — CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (Continued)

18. Indicate which of the following condition(s) the growth hormone drug is used for.

1. Noonan's syndrome.	❑ Yes	❑ No
2. Prader Willi syndrome.	❑ Yes	❑ No
3. Short stature homeobox-containing gene (SHOX) deficiency.	❑ Yes	❑ No
4. Turner syndrome.	❑ Yes	❑ No
5. Other. (Indicate condition.) ______________________________________	❑ Yes	❑ No

19. Does the member have a recent stimulated response growth hormone test? ❑ Yes ❑ No

Indicate the type of most recent stimulated response growth hormone test.
1. ❑ Arginine.
2. ❑ Clonidine.
3. ❑ Glucagon.
4. ❑ Growth hormone releasing hormone (GhRH).
5. ❑ Insulin.
6. ❑ L-Dopa.

Indicate the date of the test. ___ ___ (Month) ___ ___ ___ ___ (Year)
Indicate the test result. ___ ___. ___ ng/mL

Indicate information about additional test results (i.e., type of test, date of test, test result) in the space provided.

20. Additional documentation for PA requests for growth hormone drugs is required. Include the appropriate clinical and medical documentation for the PA consultant to make a determination about the request. Documentation may include the following: bone age results; growth charts and growth percentiles; growth plate results; growth hormone stimulation test results; imaging results; lab testing; medical office notes. Clinical documentation must be attached to each PA request.

Continued

SECTION IIIB — CLINICAL INFORMATION FOR SEROSTIM FOR AIDS WASTING DISEASE OR CACHEXIA
(Only complete this section if the member has a diagnosis of AIDS wasting disease or cachexia.)

21. **Diagnosis** — **Response (Indicate "1" for yes or "2" for no.)**
   A) The member is 18 years of age or older. _______
   B) The member has Human Immunodeficiency Virus (HIV) with serum antibodies to HIV. _______
   C) The member is female and pregnant or lactating. _______

22. **Member's Current Medical Condition**
   D) The member has signs or symptoms of AIDS or associated illnesses. _______
   E) The member has untreated or suspected serious systemic infection. _______
   F) The member has an active malignancy other than Kaposi's sarcoma. _______
   G) The member is on approved anti-retroviral therapy. _______
   H) The member has documented hypogonadism and is taking gonadal steroids. _______

23. **Evidence of Wasting Syndrome**
   I) The member has unintentional weight loss of at least 10 percent from baseline. _______
   J) The member has a gastrointestinal (GI) obstruction or malabsorption to account for weight loss. _______

   Indicate the member's height (in inches). _________________
   Indicate the member's usual weight (in pounds) prior to diagnosis of HIV. _________________
   Indicate the member's current weight (in pounds). _________________

24. **All of the following must be tried before beginning a course of therapy with a growth hormone drug**
   K) The member is receiving at least 100 percent of estimated caloric requirement on current regimen. _______
   L) The member has tried and failed a previous trial with megesterol acetate and / or dronabinal. _______
   M) The member has completed a course of therapy of at least 24 weeks of protease inhibitors alone or with nucleosides. _______
   N) The member has completed a course of therapy using dihydrotestosterone (when appropriate). _______

NEED LEVEL

Enter all 14 digits for this section in the following spaces. Do not include the measurements for the member's height, usual weight, or current weight.

___ ___ ___—___ ___ ___ ___ ___—___ ___—___ ___ ___ ___
A B C — D E F G H — I J — K L M N

SECTION IV — AUTHORIZED SIGNATURE

25. **SIGNATURE** — Prescriber	26. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

27. National Drug Code (11 Digits)	28. Days' Supply Requested (Up to 365 Days)

29. NPI

30. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

31. Place of Service

32. Assigned PA Number

33. Grant Date	34. Expiration Date	35. Number of Days Approved

Continued

SECTION VI — ADDITIONAL INFORMATION

36. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.