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 ID 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

Complete the appropriate section of this form:

- Prior authorization requests for growth hormone drugs (except Serostim® or Zorbtive®): complete Section III A only.
- Prior authorization requests for Serostim®: complete Section III B only.
- Prior authorization requests for Zorbtive®: complete Section III C only.

SECTION III A – CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (EXCEPT SEROSTIM® OR ZORBTIVE®)

14. 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.

15. Is the member 15 years of age or younger? ❑ Yes ❑ No

Continued

DT-PA038-038

SECTION III A – CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (EXCEPT SEROSTIM OR ZORBTIVE) (Continued)

16. Is the prescription for the growth hormone drug written by an endocrinologist or through an endocrinology consultation? ❑ Yes ❑ No

17. Indicate whether or not growth hormone will be used for each of the following congenital conditions.
    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

    Note: Prior authorization requests for medical conditions not listed above are not available through STAT-PA.

18. If growth hormone will not be used for one of the congenital conditions listed in Element 17, indicate the medical condition that is being treated in the space provided.

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    Prescribers should include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment. Detailed documentation of the medical work-up and testing includes, at a minimum:
    - Medical office notes.
    - Growth charts (including growth rate, growth percentiles and Z-scores) (pediatric only).
    - Lab testing.

    Additional required documentation to be submitted with the PA request when applicable includes the following:
    - Bone age results.
    - Growth plate results.
    - Other image results.
    - Growth hormone stimulation results.

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

    Indicate the type and results of the most recent stimulated response growth hormone test.

    1. ❑ Arginine Month __________ Year ________ Peak response result __________ ng/mL
    2. ❑ Clonidine Month __________ Year ________ Peak response result __________ ng/mL
    3. ❑ Glucagon Month __________ Year ________ Peak response result __________ ng/mL
    4. ❑ Insulin Month __________ Year ________ Peak response result __________ ng/mL
    5. ❑ Other: ____________________ Month ________ Year ________ Peak response result ________ ng/mL
    6. ❑ Other: ____________________ Month ________ Year ________ Peak response result ________ ng/mL
    7. ❑ Other: ____________________ Month ________ Year ________ Peak response result ________ ng/mL

    Growth hormone stimulation testing should be conducted after an overnight fast, using a well-standardized protocol. Complete testing results must be included with the PA request. The testing results must include the type of stimulation test and the dose of stimulating agent, a copy of the medical notes during the entire testing procedure, the time and results from each blood sample taken, and the provider interpretation of the testing results.

SECTION III B – CLINICAL INFORMATION FOR SEROSTIM® ONLY

20. Does the member have a diagnosis of AIDS wasting disease or cachexia? ❑ Yes ❑ No

SECTION III C – CLINICAL INFORMATION FOR ZORBTIVE® ONLY

21. Does the member have a diagnosis of short bowel syndrome with dependence on parenteral nutrition? ❑ Yes ❑ No

Continued

SECTION IV – AUTHORIZED SIGNATURE

22. **SIGNATURE** – Prescriber	23. Date Signed

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

24. National Drug Code (11 Digits)	25. Days' Supply Requested (Up to 365 Days)

26. NPI

27. 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.)

28. Place of Service

29. Assigned PA Number

30. Grant Date	31. Expiration Date	32. Number of Days Approved

SECTION VI – ADDITIONAL INFORMATION

33. 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.