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 Instructions, F-11092A. Providers may refer to the Forms page of the ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms 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, by fax, or by mail. 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 – Prescriber

11. Address – Prescriber (Street, City, State, Zip+4 Code)

12. Phone Number – Prescriber

SECTION III – CLINICAL INFORMATION

13. Diagnosis Code and Description

Complete the appropriate section of this form:

- PA requests for growth hormone drugs (except Serostim or Zorbtive): complete Section III A only.
- PA requests for Serostim: complete Section III B only.
- PA 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 prescription for the growth hormone drug written by an endocrinologist or through an endocrinology consultation? ☐ Yes ☐ No

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

1. Noonan syndrome ☐ Yes ☐ No
2. Prader-Willi syndrome ☐ Yes ☐ No
3. SHOX gene deficiency disorder ☐ Yes ☐ No
4. Turner syndrome ☐ Yes ☐ No

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

17. If growth hormone will not be used for one of the congenital conditions listed in Element 16, indicate the medical condition that is being treated in the space provided.

Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment. Documentation must include the following, when applicable based on the member's age:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Height and weight measurements over time plotted on the most clinically appropriate growth chart(s) for age and gender, including growth velocity, growth percentiles, and Z-scores
- Copies of the most recent insulin-like growth factor-1 and insulin-like growth factor-binding protein 3 lab reports
- Bone age results
- Thyroid-stimulating hormone level
- Nutrition assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

For growth hormone renewal PA requests, providers should include copies of the most recent endocrinology clinic notes, clinically appropriate height and weight growth charts for age and gender, the most current insulin-like growth factor-1 and insulin-like growth factor-binding protein 3 lab testing results, and the most current bone age when applicable based on the member's age.

18. Does the member have a recent growth hormone stimulation test? ☐ Yes ☐ No

Indicate the type and results of the most recent growth hormone stimulation 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. ☐ Macimorelin 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 submitted 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, vital signs, blood glucose levels, 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

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

SECTION III C – CLINICAL INFORMATION FOR ZORBTIVE ONLY

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

SECTION IV – AUTHORIZED SIGNATURE

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

SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA

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

25. National Provider Identifier

26. Date of Service (mm/dd/ccyy) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

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

SECTION VI – ADDITIONAL INFORMATION

32. 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.

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