Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Norditropin - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. What is the patient's diagnosis?

☐ Has the patient been diagnosed with growth failure due to growth hormone deficiency (GHD) by an endocrinologist? Must attach at least one of these for documentation must be attached: 1. Clinical assessment of appropriate auxological findings (such as growth charts, height, height velocity, chronological age, bone age) to support diagnosis of growth failure due to growth hormone deficiency (GHD); 2. Subnormal serum insulin-like growth factor (like IGF-1 or IGFBP); 3. Subnormal response to provocative growth hormone testing – Go to Question 2.

☐ Has the patient been diagnosed with short stature associated by an endocrinologist with any of the following syndromes: Noonan Syndrome, Turner Syndrome, Prader-Willi Syndrome (PWS)? Confirm that diagnosis is supported by documentation of the following: 1. Appropriate genetic test to confirm specific syndrome diagnosed; 2. Assessment of characteristic clinical features consistent with specific syndrome. Go to Question 2.

☐ Has the patient been diagnosed with short stature born Small for Gestational Age (SGA) by an endocrinologist with no catch-up growth by age 2 to 4 years? Please submit documentation of diagnosis. Go to Question 2.

☐ Has the patient been diagnosed with Idiopathic Short Stature (ISS) by an endocrinologist? Confirm that diagnosis is supported by documentation of the following: 1. Documentation of a height standard deviation score (SDS) less than -2.25 and associated with growth rates unlikely to allow one to reach normal adult height; 2. Documentation of growth chart, growth potential, impaired height velocity for age group, and bone age. Go to Question 2.

☐ Has the patient been diagnosed with adult GHD by an endocrinologist? Go to Question 9.

Q2. Is this a pediatric renewal request?

☐ Yes ☐ No

Q3. Is there documentation of continued linear growth, linear growth potential remaining, and/or open epiphyses?

☐ Yes ☐ No

Q4. Has the patient tolerated the medication without any significant side effects?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q5. Is documentation attached including the growth chart, height, chronological age, bone age (if available), growth rate, and IGF-1 level? Growth chart, labs, and notes must be attached.	
☐ Yes	☐ No
Q6. Has the patient experienced an age appropriate annualized growth rate while on growth hormone therapy?	
☐ Yes	☐ No
Q7. Given growth hormone therapy, is the patient's serum IGF-1 concentration normal? Documentation must be attached.	
☐ Yes	☐ No
Q8. Is there a plan to increase or decrease the dose of growth hormone until the serum IGF-1 concentration is normal?	
☐ Yes	☐ No
Q9. Is the diagnosis of adult GHD as a result of childhood onset GHD due to organic disease or as a result of panhypopituitarism, hypothalamic or pituitary surgery, hypothalamic or pituitary disease, radiation therapy, or trauma? Documentation must be attached.	
☐ Yes	☐ No
Q10. Has adult GHD been confirmed with a subnormal serum insulin-like growth factor-1 (IGF-1) while off of growth hormone or prior to starting growth hormone therapy? Please submit documentation.	
☐ Yes	☐ No
Q11. If the IGF-1 value is questionable or uncertain, has adult GHD been confirmed before replacement therapy is started, including subnormal provocative growth hormone stimulation tests while off of growth hormone therapy for at least 1 month? Please submit documentation.	
☐ Yes	☐ No
Q12. Is this an adult renewal request?	
☐ Yes	☐ No
Q13. Has the patient tolerated the medication without any significant side effects?	
☐ Yes	☐ No
Q14. Given growth hormone therapy, is the patient's serum IGF-1 concentration normal? Documentation must be attached.	
☐ Yes	☐ No

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Patient Name:	**Prescriber Name:**

Q15. Is there a plan to increase or decrease the dose of growth hormone until the serum IGF-1 concentration is normal?

☐ Yes ☐ No

Q16. Duration:

☐ 12 months

Q17. Additional Information:

Q18. For CMS Reporting, where does the patient reside?

☐ 00 - Not specified, other patient residence not identified below
☐ 01 - Home
☐ 03 - Nursing Facility
☐ 04 - Assisted Living Facility
☐ 06 - Group Home
☐ 09 - Intermediate Care Facility/Mentally Retarded
☐ 11 - Hospice

Prescriber Signature

Date

2019 Medicare Prior Authorization Request