PRIOR AUTHORIZATION REQUEST

GROWTH HORMONES

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 9) [] Continuation (If checked, go to 2)		
2	Does the physician certify that growth hormone (somatropin) is not being used for anti-aging, longevity, cosmetic, or enhancement of athletic performance/body building purposes?	Yes	No

If you have any questions, call: 1-888-258-8250

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PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
3	Which medication is being requested? [] Serostim (If checked, go to 4) [] All others (If checked, go to 5)		
4	Has the patient completed 48 weeks of treatment? [Note: Maximum of 48 weeks of treatment with Serostim.] [If yes, no further questions.]	Yes	No
5	Is the patient currently receiving the requested medication? [If no, skip to question 9.]	Yes	No
6	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
7	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
8	Has documentation been submitted to confirm that the patient has experienced a clinically significant response as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
9	Does the physician certify that growth hormone (somatropin) is not being used for anti-aging, longevity, cosmetic, or enhancement of athletic performance/body building purposes? [If no, no further questions.]	Yes	No
10	What medication is being requested? [] Omnitrope (If checked, go to 19) [] Genotropin (If checked, go to 17) [] Humatrope (If checked, go to 17) [] Norditropin (If checked, go to 17) [] Nutropin (If checked, go to 17) [] Saizen (If checked, go to 17)		

PRIOR AUTHORIZATION REQUEST

[] Serostim (If checked, go to 97)

[] Zomacton (If checked, go to 17)

[] Sogroya (If checked, go to 11)

[] Skytrofa (If checked, go to 13)

[] Ngenla (If checked, go to 15)

[] Other (If checked, go to 17)

11 Is the patient greater than or equal to 2.5 years of age? Yes No
[If no, no further questions.]

12 What is the indication or diagnosis?

[] Pediatric growth hormone deficiency (If checked, go to 17)

[] Adult growth hormone deficiency (If checked, go to 17)

[] Noonan Syndrome (If checked, go to 17)

[] Idiopathic short stature (If checked, go to 17)

[] All others (If checked, no further questions)

13 Is the patient greater than or equal to 1 year of age and weighs at least 11.5 kg? Yes No
[If no, no further questions.]

14 What is the indication or diagnosis?

[] Pediatric growth hormone deficiency (If checked, go to 17)

[] Adult growth hormone deficiency (If checked, go to 17)

[] All others (If checked, no further questions)

15 Is the patient greater than or equal to 3 years of age? Yes No
[If no, no further questions.]

16 What is the indication or diagnosis?

[] Pediatric growth hormone deficiency (If checked, go to 17)

[] All others (If checked, no further questions)

PRIOR AUTHORIZATION REQUEST

17	Is the request for a formulary growth hormone product (Omnitrope)? [If yes, skip to question 19.]	Yes	No
18	Does the patient have documented intolerance, contraindication to, or failed treatment for at least 3 months with preferred growth hormone product (Omnitrope)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
19	Which of the following best describes the patient? [NOTE: If the adolescent who was previously on growth hormone has stopped growing, the epiphyses are closed, or mid-parental height has been attained, they may be reviewed as a transition adolescent or as an adult with growth hormone deficiency OR as an adult with Prader Willi syndrome.]		
	[] Child or adolescent whose epiphyses are still open AND who has not reached their mid-parental height (If checked, go to 20)		
	[] Transition adolescent (If checked, go to 68)		
	[] Adult (If checked, go to 83)		
20	What is the indication or diagnosis?		
	[] Pediatric growth hormone deficiency (If checked, go to 21)		
	[] Prader-Willi syndrome (If checked, go to 34)		
	[] Non-growth hormone deficient short stature (idiopathic short stature) (If checked, go to 38)		
	[] SHOX (short stature homeobox-containing gene) deficiency (If checked, go to 44)		
	[] Growth failure in child or adolescent with chronic kidney disease (CKD) (If checked, go to 49)		
	[] Children born small for gestational age (SGA) or with intrauterine growth restriction (retardation) (IUGR) including those with Silver-Russell syndrome (If checked, go to 53)		
	[] Noonan syndrome (If checked, go to 59)		
	[] Patients with short stature associated with Turner syndrome (If checked, go to 64)		
	[] All others (If checked, no further questions)		
21	Is the patient less than 18 years of age?	Yes	No

PRIOR AUTHORIZATION REQUEST

	[If no, no further questions.]		
22	Has documentation been provided to confirm a diagnosis of pediatric growth hormone deficiency? ACTION REQUIRED: Submit supporting documentation. [Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
23	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [Note: Growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
24	Has documentation been provided to confirm that the patient has one of the following? ACTION REQUIRED: Submit supporting documentation. [] Previous radiation to the brain or tumor resection of a child (If checked, go to 25) [] Congenital hypopituitarism (If checked, go to 26) [] Panhypopituitarism (If checked, go to 27) [] Hypophysectomy (surgical removal of pituitary gland) (If checked, go to 32) [] None of the above (If checked, go to 29)		
25	Does the patient meet ONE of the following: A) The patient had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the test shows an inadequate response as defined by a peak GH response which is below the normal reference range as determined by the testing laboratory, or B) The patient has a deficiency in at least one other pituitary hormone (that is, adrenocorticotropic hormone [ACTH], thyroid-stimulating hormone [TSH], gonadotropin deficiency [luteinizing hormone (LH) and/or follicle stimulating hormone (FSH) deficiency are counted as one deficiency], or prolactin)? [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
26	Does the patient meet ONE of the following: A) The patient had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the test shows an inadequate response as defined by a peak GH response which is below the normal reference range as determined by the testing laboratory, or B) The patient has a deficiency in at least one other pituitary hormone deficiency that are counted as one deficiency and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk? ACTION	Yes	No

PRIOR AUTHORIZATION REQUEST

	REQUIRED: Submit supporting documentation. [If yes, skip to question 32.] [If no, no further questions.]		
27	Does the patient have three or more of the following pituitary hormone deficiencies: somatropin (growth hormone), adrenocorticotropic hormone (ACTH), thyroid stimulating hormone (TSH), gonadotropin deficiency (luteinizing hormone [LH] and/or follicle stimulating hormone [FSH] deficiency are counted as one deficiency), and prolactin? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 32.]	Yes	No
28	Has the patient had one growth hormone stimulation test with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the test shows an inadequate response as defined by a peak GH response which is below the normal reference range as determined by the testing laboratory? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 32.] [If no, no further questions.]	Yes	No
29	Has the patient had TWO growth hormone (GH) stimulation tests performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND both tests show an inadequate response as defined by a peak GH response which is below the normal reference range as determined by the testing laboratory? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 32.]	Yes	No
30	Has the patient had one growth hormone (GH) stimulation test performed with any of the following agents: levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon AND the test shows an inadequate response as defined by a peak GH response which is below the normal reference range as determined by the testing laboratory? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 32.]	Yes	No
31	Does the patient have at least one risk factor for growth hormone deficiency? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
33	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose per guideline recommendations: A) SUBQ: Initial dose: 0.16 to 0.24 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, B) Genotropin, Omnitrope: SUBQ: 0.16 to 0.24 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, C) Humatrope: SUBQ:	Yes	No

PRIOR AUTHORIZATION REQUEST

	0.18 to 0.3 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, D) Norditropin: SUBQ: 0.17 to 0.24 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, E) Nutropin AQ: SUBQ: 0.3 mg/kg WEEKLY divided into daily doses, F) Saizen: SUBQ: 0.18 mg/kg WEEKLY divided into equal doses 3, 6, or 7 days/week, G) Zomacton: SUBQ: 0.18 to 0.3 mg/kg WEEKLY divided into equal doses 3, 6, or 7 days/week, H) Ngela: SUBQ: 0.66 mg/kg/dose once WEEKLY, I) Sogroya: SUBQ: 0.16 mg/kg/dose once WEEKLY, J) Skytrofa: SUBQ: 0.24 mg/kg/dose once WEEKLY. [No further questions.]		
34	Has documentation been provided to confirm diagnosis of Prader-Willi Syndrome? ACTION REQUIRED: Submit supporting documentation. [Note: Genetic testing required.] [If no, no further questions.]	Yes	No
35	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [Note: Documentation must include baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
36	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
37	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is Genotropin, Norditropin, Omnitrope: SUBQ: 0.24 mg/kg WEEKLY divided daily into 6 to 7 doses/week. [No further questions.]	Yes	No
38	Has documentation been provided to confirm diagnosis of idiopathic short stature? ACTION REQUIRED: Submit supporting documentation. [Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
39	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
40	Is the patient greater than or equal to 5 years of age? [If no, no further questions.]	Yes	No
41	Does the patient have constitutional delay of growth and puberty (CDGP)? [If yes, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

42	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
43	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose per guideline recommendations*:* A) SUBQ: Initial dose: 0.24 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, B) Genotropin, Norditropin, Omnitrope: SUBQ: Up to 0.47 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, C) Humatrope: SUBQ: Up to 0.37 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, D) Nutropin AQ: SUBQ: Up to 0.3 mg/kg WEEKLY divided into daily doses, E) Zomacton: SUBQ: Up to 0.37 mg/kg WEEKLY divided into equal doses 3, 6, or 7 days/week, F) Sogroya: SUBQ: 0.24 mg/kg/dose once WEEKLY. [No further questions.]	Yes	No
44	Has documentation been provided to confirm diagnosis of SHOX? ACTION REQUIRED: Submit supporting documentation. [Note: Genetic testing required.] [If no, no further questions.]	Yes	No
45	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
46	At baseline, is the patient's height less than the 3rd percentile for age and gender? [If no, no further questions.]	Yes	No
47	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
48	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is Humatrope, Zomacton: SUBQ: 0.35 mg/kg WEEKLY divided into equal doses 6 to 7 days/week. [No further questions.]	Yes	No
49	Does the patient have or has had chronic kidney disease (CKD) as defined by abnormal creatinine clearance? [If no, no further questions.]	Yes	No
50	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation.	Yes	No

PRIOR AUTHORIZATION REQUEST

	[Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]		
51	Is the requested medication prescribed by or in consultation with an endocrinologist or a nephrologist? [If no, no further questions.]	Yes	No
52	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is Nutropin AQ: SUBQ: 0.35 mg/kg WEEKLY divided into daily injections. [No further questions.]	Yes	No
53	Has documentation been provided to confirm a diagnosis of SGA or IUGR? ACTION REQUIRED: Submit supporting documentation. [Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
54	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
55	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
56	Was the patient's birth weight and/or birth length greater than 2 standard deviations (SD) below the mean for gestational age and gender AND the patient did not have sufficient catch-up growth before age 2 to 4 years? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
57	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
58	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose per guideline recommendations*:* A) SUBQ: 35 to 70 mcg/kg/day once DAILY, B) Genotropin, Omnitrope: Up to 0.48 mg/kg WEEKLY divided daily into 6 to 7 doses/week, C) Humatrope, Norditropin: SUBQ: Up to 0.47 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, D) Zomacton: SUBQ: Up to 0.47 mg/kg WEEKLY divided into equal doses 3, 6, or 7 days/week, E) Sogroya: SUBQ: 0.24 mg/kg/dose once WEEKLY. [No further questions.]	Yes	No
59	Has documentation been provided to confirm a diagnosis of Noonan Syndrome?	Yes	No

PRIOR AUTHORIZATION REQUEST

	ACTION REQUIRED: Submit supporting documentation. [Note: Genetic testing required.] [If no, no further questions.]		
60	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
61	At baseline, is the patient's height less than the 5th percentile using a growth chart for children without Noonan syndrome? [If no, no further questions.]	Yes	No
62	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
63	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is A) Norditropin: SUBQ: Up to 0.46 mg/kg WEEKLY divided in equal doses 6 to 7 days/week, B) Sogroya: SUBQ: 0.24 mg/kg/dose once WEEKLY. [No further questions.]	Yes	No
64	Has documentation been provided to confirm a diagnosis of Turner Syndrome? ACTION REQUIRED: Submit supporting documentation. [Note: Genetic testing required.] [If no, no further questions.]	Yes	No
65	Has documentation been provided to confirm epiphyses are still open AND the patient has not reached their mid-parental height? ACTION REQUIRED: Submit supporting documentation. [Note: Baseline height/weight and growth chart including height/weight for age/gender and calculated growth velocity.] [If no, no further questions.]	Yes	No
66	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
67	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose per guideline recommendations: A) Children at least 4 years of age and Adolescents: SUBQ: 0.35 to 0.375 mg/kg WEEKLY divided into equal doses 7 days/week, B) Genotropin; Omnitrope: SUBQ: 0.33 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, C) Humatrope: SUBQ: 0.375 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, D) Norditropin: SUBQ: Up to 0.47 mg/kg WEEKLY	Yes	No

PRIOR AUTHORIZATION REQUEST

	divided into equal doses 6 to 7 days/week, E) Nutropin AQ: SUBQ: Up to 0.375 mg/kg WEEKLY divided into equal doses 6 to 7 days/week, F) Zomacton: SUBQ: Up to 0.375 mg/kg WEEKLY divided into equal doses 3, 6, or 7 days/week. [No further questions.]		
68	Has documentation been provided to confirm that the patient has childhood onset GH deficiency from one of the following: GH deficiency alone or multiple hormone deficiencies (hypopituitarism) resulting from pituitary disease, hypothalamic disease, pituitary surgery, cranial radiation therapy, tumor treatment, traumatic brain injury, or subarachnoid hemorrhage? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 71.]	Yes	No
69	Does the transition adolescent patient have known mutations, embryopathic lesions, congenital or genetic defects, or structural hypothalamic-pituitary defects? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 71.]	Yes	No
70	Does the adult or transition adolescent have three or more of the following pituitary hormone deficiencies: adrenocorticotropic hormone (ACTH), thyroid stimulating hormone (TSH), gonadotropin deficiency (luteinizing hormone [LH] and/or follicle stimulating hormone [FSH] deficiency are counted as one deficiency), and prolactin? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
71	Has documentation been provided to confirm that the patient has an age and gender adjusted serum IGF-1 below the lower limits of the normal reference range for the reporting laboratory? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
72	Have other causes of low serum IGF-1 been excluded (for example, malnutrition, prolonged fasting, poorly controlled diabetes mellitus, hypothyroidism, hepatic insufficiency, oral estrogen therapy)? [If no, no further questions.]	Yes	No
73	Has documentation been provided to confirm that as a transition adolescent, the patient has been off somatropin therapy (growth hormone) for at least one month before being retested with a growth hormone stimulation test? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
74	Has the transition adolescent patient had a negative response to one of the following standard growth hormone stimulation tests? ACTION REQUIRED: Submit supporting documentation. [] Insulin tolerance test less than or equal to 5 mcg/L (If checked, go to 75)		

PRIOR AUTHORIZATION REQUEST

[] Glucagon stimulation test less than or equal to 1 mcg/L for BMI greater than 30 kg/m2 (If checked, go to 76)

[] Glucagon stimulation test less than or equal to 3 mcg/L for BMI less than 30 kg/m2 (If checked, go to 77)

[] Arginine alone test (If checked, go to 78)

[] Macrilen (macimorelin) test less than or equal to 2.8 mcg/L (If checked, go to 80)

[] No (If checked, no further questions)

75	Has documentation been provided to confirm the transition adolescent patient had a peak response of 5 micrograms per liter or less with the insulin tolerance test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 81.] [If no, no further questions.]	Yes	No
76	Has documentation been provided to confirm the transition adolescent patient had a peak response of 1.0 micrograms/liter or less with the glucagon stimulation test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 81.] [If no, no further questions.]	Yes	No
77	Has documentation been provided to confirm the transition adolescent patient had a peak response of 3.0 micrograms/liter or less with the glucagon stimulation test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 81.] [If no, no further questions.]	Yes	No
78	Has documentation been provided to confirm that the transition adolescent patient has contraindications to both the insulin tolerance test and the glucagon stimulation test? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
79	Has documentation been provided to confirm that the transition adolescent patient had a peak response of 0.4 micrograms/liter or less with the arginine alone test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 81.] [If no, no further questions.]	Yes	No
80	Has documentation been provided to confirm that the transition adolescent patient had a Macrilen (macimorelin) test with a peak response of 2.8 nanograms/milliliter (2.8 micrograms/liter) or less? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No

PRIOR AUTHORIZATION REQUEST

81	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
82	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is A) Humatrope, Genotropin, Nutropin AQ, Zomacton: weight based or a non-weight based dosing may be followed, B) Omnitrope: Up to 0.08 mg/kg/week, C) Humatrope: Up to 0.0125 mg/kg daily, D) Genotropin: 0.04 mg/kg/week, E) Nutropin AQ: Up to 0.0125 mg/kg daily, F) Serostim: Up to 6 mg subcutaneously daily, G) Zomacton: Up to 0.0125 mg/kg daily, H) Norditropin: Up to 0.016 mg/kg daily, I) Sogroya: Up to 8 mg once weekly, J) Skytrofa: Up to 6.3 mg once weekly. [No further questions.]	Yes	No
83	Has documentation been provided to confirm that the adult patient has childhood onset GH deficiency from one of the following: GH deficiency alone or multiple hormone deficiencies (hypopituitarism) resulting from pituitary disease, hypothalamic disease, pituitary surgery, cranial radiation therapy, tumor treatment, traumatic brain injury, or subarachnoid hemorrhage? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 86.]	Yes	No
84	Has documentation been provided to confirm that the adult patient has known mutations, embryopathic lesions, congenital or genetic defects, or structural hypothalamic-pituitary defects? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 86.]	Yes	No
85	Has documentation been provided to confirm that the adult patient has THREE or more of the following pituitary hormone deficiencies: adrenocorticotropic hormone (ACTH), thyroid stimulating hormone (TSH), gonadotropin deficiency (luteinizing hormone [LH] and/or follicle stimulating hormone [FSH] deficiency are counted as one deficiency), and prolactin? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
86	Has documentation been provided to confirm that the patient has an age and gender adjusted serum IGF-1 below the lower limits of the normal reference range for the reporting laboratory? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
87	Have other causes of low serum IGF-1 been excluded (for example, malnutrition, prolonged fasting, poorly controlled diabetes mellitus, hypothyroidism, hepatic insufficiency, oral estrogen therapy)? [If no, no further questions.]	Yes	No
88	Has the adult patient had a negative response to one of the following standard		

PRIOR AUTHORIZATION REQUEST

	growth hormone stimulation tests? ACTION REQUIRED: Submit supporting documentation. [] Insulin tolerance test less than or equal to 5 mcg/L (If checked, go to 89) [] Glucagon stimulation test less than or equal to 1 mcg/L for BMI greater than 30 kg/m2 (If checked, go to 90) [] Glucagon stimulation test less than or equal to 3 mcg/L for BMI less than 30 kg/m2 (If checked, go to 91) [] Arginine alone test (If checked, go to 92) [] Macrilen (macimorelin) test less than or equal to 2.8 mcg/L (If checked, go to 94) [] No (If checked, no further questions)		
89	Has documentation been provided to confirm the adult patient had a peak response of 5 micrograms per liter or less with the insulin tolerance test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 95.] [If no, no further questions.]	Yes	No
90	Has documentation been provided to confirm the adult patient had a peak response of 1.0 micrograms/liter or less with the glucagon stimulation test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 95.] [If no, no further questions.]	Yes	No
91	Has documentation been provided to confirm the adult patient had a peak response of 3.0 micrograms/liter or less with the glucagon stimulation test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 95.] [If no, no further questions.]	Yes	No
92	Has documentation been provided to confirm that the adult patient has contraindications to both the insulin tolerance test and the glucagon stimulation test? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
93	Has documentation been provided to confirm that the adult patient had a peak response of 0.4 micrograms/liter or less with the arginine alone test? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 95.] [If no, no further questions.]	Yes	No
94	Has documentation been provided to confirm that the adult patient had a Macrilen (macimorelin) test with a peak response of 2.8 nanograms/milliliter (2.8	Yes	No

PRIOR AUTHORIZATION REQUEST

	micrograms/liter) or less? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]		
95	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
96	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is A) Humatrope, Genotropin, Nutropin AQ, Zomacton: weight based or a non-weight based dosing may be followed, B) Omnitrope: Up to 0.08 mg/kg/week, C) Humatrope: Up to 0.0125 mg/kg daily, D) Genotropin: 0.04 mg/kg/week, E) Nutropin AQ: Up to 0.0125 mg/kg daily, F) Serostim: Up to 6 mg subcutaneously daily, G) Zomacton: Up to 0.0125 mg/kg daily, H) Norditropin: Up to 0.016 mg/kg daily, I) Sogroya: Up to 8 mg once weekly, J) Skytrofa: Up to 6.3 mg once weekly. [No further questions.]	Yes	No
97	What is the indication or diagnosis? [] Adults with HIV infection with wasting or cachexia (If checked, go to 98) [] Other (If checked, no further questions)		
98	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
99	Does the patient have a documented unintentional weight loss of greater than or equal to 10% from baseline? ACTION REQUIRED: Submit supporting documentation. [NOTE: The following formula can be used to calculate BMI: BMI equals body weight in kilograms divided by height in meters squared (m2) (that is, BMI equals kg/m2).] [If yes, skip to question 102.]	Yes	No
100	Is the patient's weight less than 90% of the lower limit of ideal body weight? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 102.]	Yes	No
101	Does the patient have a body mass index (BMI) of less than or equal to 20 kg/m2? ACTION REQUIRED: Submit supporting documentation. [NOTE: The following formula can be used to calculate BMI: BMI equals body weight in kilograms divided by height in meters squared (m2) (that is, BMI equals kg/m2).] [If no, no further questions.]	Yes	No
102	Has wasting or cachexia that is due to malabsorption, poor diet, opportunistic infection, depression, and other causes been addressed prior to starting	Yes	No

PRIOR AUTHORIZATION REQUEST

	Serostim? [If no, no further questions.]		
103	Has the patient been on antiretroviral therapy or highly active antiretroviral treatment (HAART) for greater than or equal to 30 days prior to beginning therapy with Serostim AND will continue antiretroviral therapy throughout the course of treatment with Serostim? [If no, no further questions.]	Yes	No
104	Is Serostim being used solely for the treatment of alterations in body fat distribution such as increased abdominal girth, lipodystrophy and excess abdominal fat, buffalo hump? [If yes, no further questions.]	Yes	No
105	Is the requested medication prescribed by or in consultation with an endocrinologist? [If no, no further questions.]	Yes	No
106	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dose is Serostim max dose up to 6 mg daily.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 1-888-258-8250