AmWINS Rx

Date of Request:______________________

Sterling Retiree Rx Prior Authorization Form

GROWTH HORMONE (Somatropin)

Coverage Criteria / Required Medical Information
Prescriber must be Endocrinologist, Pediatric Nephrologist, Gastroenterologist, Nutritional Support Specialist or Infectious Disease Specialist

Neonate with Hypoglycemia: patient has pediatric GHD **and** randomly assigned GH level of < 20 ng/mL
SBS: patient is receiving specialized nutritional support **and** patient has not received GH therapy for more than 8 weeks lifetime
HIV Wasting: patient is on antiretroviral therapy, has tried and failed alternative therapies such as dronabinol or megestrol **and** alternative causes of wasting have been ruled out. **To continue therapy for HIV wasting,** BMI has improved or stabilized, and it has been at least 4 weeks since completion of last round of GH therapy.
All Pediatric Patients: patients have short stature and have been evaluated for other causes of growth failure.
Pediatric GHD: has delayed bone age and failed 2 stimulation tests.
Pediatric GHD with a Pituitary or CNS disorder: patient has clinical evidence of GHD and low IGF-1/IGFBP3.
Turner Syndrome Patient: diagnosis confirmed with karyotyping **and** ≥ 2 years of age
Chronic Renal Insufficiency Patients: metabolic, endocrine and nutritional abnormalities have been treated or stabilized and patient has not had a kidney transplant.
SGA patient: had a low birth weight **and** has failed to manifest catch up growth by age 2 **and** ≥ 2 years of age
PWS Patient: therapy will be discontinued if patient develops severe respiratory impairment
SHOX Patient and Noonan Syndrome: diagnosis confirmed by molecular or genetic testing and ≥ 3 years of age
Adult: assessed for other causes of GHD-like symptoms **and** failed 2 stimulation tests
Adult GHD with at least 3 pituitary hormone deficiencies or Panhypopituitarism: have a low IGF-1
Adult GHD with less than 3 pituitary hormone deficiencies: low IGF-1 **and** failed one stimulation test

Continuation of Therapy
Pediatric Patients: growing more than 2 cm per year, open epiphyses **and for PWS only:** improved body composition.
Adult Patients: clinical improvement **and** IGF-1 to confirm appropriateness of treatment.

Coverage Duration: 12 weeks for HIV wasting, 8 weeks lifetime for SBS, 12 months for all other indications

Exclusion Criteria
malignancy; diabetic retinopathy; acute critical illness; concurrent use with Increlex; closed epiphyses for all pediatric patients; upper airway obstruction for PWS only; other causes of hypoglycemia have been ruled out for neonates with hypoglycemia; pediatric GHD has been ruled out for ISS with one stimulation test

Member Information					
Name					
Enrollment/Card-holder ID Number					
Group/Plan		**Male**		**Female**	
Date of Birth		**Age**		**Weight in Kg**	
Street Address					
City		**State**		**Zip**	

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Physicians Information					
Name					
Agent		**Contact Name**			
Specialty/Office					
Clinic Name					
Street Address					
City		**State**		**Zip**	
Phone		**Fax**			

Requested Drug		
GROWTH HORMONES	**Reason for Request**	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request				
Labs: Baseline/Ongoing	**Strength/Dosage**			
Formulary Alternative(s) Attempted?	**Yes:**		**No:**	
Please List Alternative Formulary Drugs				
Comments				

Physicians Signature: ___________________________________ **Fax Form to 1-866-481-3704**