



**Prescription Drug Coverage Determination Form**

Growth Hormones

Humatrope®, Genotropin®, Norditropin®, Nutropin®, Nutropin AQ®, Saizen®  
(somatropin) injectables

Please fax the completed form to Mercy Health Plans' Pharmacy Department  
at 314-214-8201 or 1-800-647-2240.

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Subscriber ID#: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Physician Information**

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Tax ID#: \_\_\_\_\_  
Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person \_\_\_\_\_

Physician Signature (REQUIRED): \_\_\_\_\_ Date \_\_\_\_\_

Medication Information (requests for non-formulary agents will be considered for  
members having a documented failure or contraindication to preferred agents.)

Medication name: \_\_\_\_\_ J-code: \_\_\_\_\_  
Dose: \_\_\_\_\_ Directions: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_

**Prior Authorization Criteria:**

Does the patient have one of the following diagnosis:

- 1. Growth failure in pediatric patients due to inadequate secretion of normal endogenous growth hormone whose epiphyses are not closed?  Yes  No
- 2. Short stature associated with Turner syndrome?  Yes  No
- 3. Growth failure due to Prader-Willi syndrome?  Yes  No  
If yes:
  - Does the patient have a history of severe respiratory impairment or sleep apnea?  Yes  No
- 4. At birth, was the patient small for gestational age (defined as more than 2 standard deviations below normal for height and weight) and failed to manifest catch-up growth by age 2?  Yes  No
- 5. Adult patients with growth hormone deficiency either alone or associated with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy or trauma, or who were growth hormone deficient during childhood as a result of congenital, genetic, acquired, or idiopathic causes?  Yes  No
- 6. Idiopathic short stature?  Yes  No

7. Short stature or growth failure in children with SHOX (short stature homeobox-containing gene) deficiency whose epiphyses are not closed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Children with short stature associated with Noonan syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Short stature associated with chronic renal insufficiency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient received a kidney transplant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Treatment of adult AIDS patients with cachexia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Has the patient failed one growth hormone (GH) stimulation tests [failure is defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia]?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has the patient received at least 6 months of therapy through pharmacy benefit in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes:		
▪ Has the patient been evaluated for continuation of therapy (e.g. thyroid level, lipid level, body composition, measurements and bone densitometry)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the height of the patient increased in the past 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the growth velocity of the patient improved since the initiation of growth hormone therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the physician evaluated the patient's serum insulin-like growth factor 1 (IGF-1) to confirm the appropriateness of the dose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Has the patient had improvement in symptoms (e.g., decreased in body fat, increased bone density, better endurance, less fatigue) and clinical features of growth hormone deficiency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): \_\_\_\_\_

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.