



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Growth Hormones

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health 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.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: <input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
<i>Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..</i>			

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. Is this a request for initiation of therapy with the requested drug?

[If no, skip to question 48.]

Yes

No

Q2. Is the requested drug prescribed for the treatment of a diagnosis that is indicated in the United States Food and Drug Administration (FDA)-approved package label or a medically accepted indication?

Yes

No

Q3. Is the patient's age appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

No

Q4. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

Yes

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<p>Q5. Is the requested drug prescribed by an appropriate specialist (e.g. endocrinologist, gastroenterologist or neonatologist [in the neonatal period])?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Does the member have a history of a contraindication to the requested drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is this a request for a preferred product?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Does the patient have a history of therapeutic failure of the preferred products approved or medically accepted for the member's diagnosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Is this a request for short bowel syndrome?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is the patient a neonate? [If no, skip to question 13.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Does the patient have a diagnosis of growth hormone deficiency confirmed according to the current consensus guidelines (e.g. Pediatric Endocrine Society)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q12. Has appropriate imaging (magnetic resonance imaging [MRI] or computed tomography [CT]) of the brain been done, with particular attention to the hypothalamic pituitary region, to exclude the possibility of a tumor?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q13. Does the patient have acquired immunodeficiency syndrome (AIDS) related cachexia? [If yes, skip to question 43.]</p>

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<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q22. Is the patient's height greater than 2.25 standard deviation (SD) below the mean for age or greater than two SD below the mid-parental height percentile? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q23. Is the growth velocity below the 25th percentile for bone age? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q24. Have secondary causes of insulin-like growth factor (IGF)-1 deficiency been excluded (i.e. under-nutrition and hepatic disease)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q25. Does the patient have a history of passed growth hormone stimulation tests? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q26. Does the patient have a diagnosis of chronic renal failure? [If no, skip to question 29.] <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q27. Does the patient have a diagnosis of pediatric growth failure (defined by height greater than two standard deviations (SD) below the mean for age and gender) due to chronic renal failure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q28. Has the patient had a renal transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q29. Does the patient have a diagnosis of small for gestational age (SGA)? [If no, skip to question 32.] <input type="checkbox"/> Yes <input type="checkbox"/> No	

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Q30. Does the patient meet either of the following: A) Patient was born with a birth weight of less than 2500 grams at a gestational age of 37 weeks or more, or B) Patient' weight or length at birth was greater than two standard deviations (SD) below the mean for gestational age?

Yes

No

Q31. Did the patient fail to manifest catch-up growth by two years of age (defined as height at least two standard deviations [SD] below the mean for age and gender)?

Yes

No

Q32. Does the patient have a diagnosis of Turner syndrome, Noonan syndrome or Short Stature Homeobox (SHOX) Syndrome?
 [If no, skip to question 34.]

Yes

No

Q33. Has it been confirmed the patient's growth failure (defined as height greater than two standard deviations (SD) below the age-related mean) is caused by a documented diagnosis of Turner syndrome, Noonan syndrome or Short Stature Homeobox (SHOX) Syndrome? Note: please attach documentation.

Yes

No

Q34. Does the patient have a diagnosis of Prader-Willi syndrome? Note: Please attach documentation to confirm diagnosis.

Yes

No

Q35. Is the patient receiving treatment for Prader-Willi syndrome manifestations and co-morbidities?

Yes

No

Q36. Does the patient have growth failure defined as height greater than two standard deviations (SD) below the age-related mean?

Yes

No

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<p>Q37. Does the patient have one of the following: A) No symptoms of sleep apnea or B) A history of sleep apnea or symptoms consistent with sleep apnea and has been fully evaluated and treated?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q38. Does the patient have a diagnosis of growth hormone deficiency confirmed according to the current consensus guidelines (e.g. American Association of Clinical Endocrinologists)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q39. Does the patient have a documented history of adult growth hormone deficiency a result of one of the following: A) Childhood-onset growth hormone deficiency, B) Pituitary or hypothalamic disease, C) Surgery or radiation therapy, D) Trauma?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q40. Is the patient currently receiving replacement therapy for any other pituitary hormone deficiencies that is consistent with current medical standards of practice?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q41. Does the patient have a traumatic brain injury or subarachnoid hemorrhage?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q42. Has the patient received stimulation testing at least 12 months after the date of the injury? Note: Please attach documentation of lab tests.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q43. Does the patient have a diagnosis of wasting syndrome defined by a body mass index (BMI) less than or equal to 18.5?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q44. Does the patient have a diagnosis of wasting syndrome defined by both of the following: A) body mass index (BMI) less than or equal to 25, and B) unintentional or unexplained weight loss defined by one of the following: 1) Weight loss of at least 10 percent from baseline pre-morbid</p>



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weight or 2) a BMI of less than 20 in the absence of a concurrent illness or medical condition [other than human immunodeficiency virus (HIV)] that would explain these findings?

Yes

No

Q45. Is it confirmed that wasting syndrome is not attributable to other causes, such as depression, Mycobacterium avium complex infection, chronic infectious diarrhea, or malignancy? Note: Kaposi's sarcoma limited to the skin or mucous membranes is excluded.

Yes

No

Q46. Is the patient currently on a comprehensive acquired immunodeficiency syndrome (AIDS) treatment program, including antiretroviral therapy?

Yes

No

Q47. Has the patient had an inadequate response or intolerance to both of the following: A) Nutritional supplements that increase caloric and protein intake and B) Steroid hormones such as megestrol?

Yes

No

Q48. Is the requested drug being prescribed by an appropriate specialist (e.g. neonatologist [in the neonatal period], endocrinologist, or gastroenterologist)?

Yes

No

Q49. Is the prescribed dose and duration of therapy consistent with Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes

No

Q50. Is the patient age-appropriate for the requested drug according to Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia or peer-reviewed medical literature?

Yes

No



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Q51. Does the patient have a history of contraindication to the requested drug?

Yes

No

Q52. Is this request for a dose increase?

Yes

No

Q53. Does the patient demonstrate compliance with the requested medication?

Yes

No

Q54. Is the patient a neonate?

Yes

No

Q55. Is the current insulin-like growth factor (IGF)-1 concentration in the normal range for age and gender?

Yes

No

Q56. Does the patient have a diagnosis of acquired immunodeficiency syndrome (AIDS)-related cachexia?

[If yes, skip to question 69.]

Yes

No

Q57. Is the patient at least 18 years of age or have closed epiphyses?

[If yes, skip to question 67.]

Yes

No

Q58. Does the patient meet any of the following: A) Patient is female at least 12 years old, B) Patient is a male at least 14 years old, C) Patient is in Tanner stage three or higher?

Yes

No

Q59. Are the epiphyses confirmed open?

Yes

No

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<p>Q60. Has the patient reached puberty?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q61. Has the patient demonstrated a growth response of at least 2.5 centimeters per year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q62. Has the patient demonstrated a growth response of at least 4.5 centimeters per year?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q63. Is the insulin-like growth factor (IGF)-1 concentration in the normal range for age and gender?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q64. Has the patient reached expected final adult height (mid-parental height)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q65. Does the patient have a diagnosis of Prader-Willi syndrome?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q66. Has the patient shown improvement in any of the following since starting the requested drug: A) Lean-to-fat body mass or B) Growth velocity?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

<p>Q67. Has the patient experienced clinical benefit since starting the requested drug as evidenced by one of the following: A) Increase in total lean body mass, B) Increase in exercise capacity, C) Improved energy level?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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<p>Q68. Does the patient have a normal insulin-like growth factor (IGF)-1 concentration?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Q69. Has the patient demonstrated any of the following since starting the requested medication:
A) Weight stabilization or B) Weight increase?

Yes No

Q70. Additional Information:

Prescriber Signature

Date

v2026-06