

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:		Prescriber Name:	
HPP Member Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Primary Phone:	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>HPP's maximum approval time is 12 months but may be less depending on the drug.</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

 No

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<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>	

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is the patient at least 18 years old, or are their epiphyses closed? [If yes, skip to question 38.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Have the epiphyses been confirmed as open?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Has growth failure due to idiopathic short stature, familial short stature or constitutional growth delay been ruled out?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Have all other causes of short stature been excluded?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Does the patient have a diagnosis of growth hormone deficiency confirmed according to the current consensus guidelines (e.g. Pediatric Endocrine Society)?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q21. Does the patient have a diagnosis of insulin-like growth factor (IGF)-1 deficiency? [If no, skip to question 26.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q23. Is the growth velocity below the 25th percentile for bone age?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q24. Have secondary causes of insulin-like growth factor (IGF)-1 deficiency been excluded (i.e. under-nutrition and hepatic disease)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q25. Does the patient have a history of passed growth hormone stimulation tests?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q26. Does the patient have a diagnosis of chronic renal failure? [If no, skip to question 29.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q28. Has the patient had a renal transplant?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q29. Does the patient have a diagnosis of small for gestational age (SGA)? [If no, skip to question 32.]</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p>	

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>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)?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q32. Does the patient have a diagnosis of Turner syndrome, Noonan syndrome or Short Stature Homeobox (SHOX) Syndrome? [If no, skip to question 34.]</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>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.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q34. Does the patient have a diagnosis of Prader-Willi syndrome? Note: Please attach documentation to confirm diagnosis.</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q35. Is the patient receiving treatment for Prader-Willi syndrome manifestations and co-morbidities?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q36. Does the patient have growth failure defined as height greater than two standard deviations (SD) below the age-related mean?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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>	

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
<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> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<p>Q41. Does the patient have a traumatic brain injury or subarachnoid hemorrhage?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<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 premorbid 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?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<p>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.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q46. Is the patient currently on a comprehensive acquired immunodeficiency syndrome (AIDS) treatment program, including antiretroviral therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q48. Is the requested drug being prescribed by an appropriate specialist (e.g. neonatologist [in the neonatal period], endocrinologist, or gastroenterologist)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q51. Does the patient have a history of contraindication to the requested drug?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Q52. Is this request for a dose increase?</p>	

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q53. Does the patient demonstrate compliance with the requested medication?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q54. Is the patient a neonate?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q55. Is the current insulin-like growth factor (IGF)-1 concentration in the normal range for age and gender?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q56. Does the patient have a diagnosis of acquired immunodeficiency syndrome (AIDS)-related cachexia? [If yes, skip to question 69.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q57. Is the patient at least 18 years of age or have closed epiphyses? [If yes, skip to question 67.]	
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q59. Are the epiphyses confirmed open?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q60. Has the patient reached puberty?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q61. Has the patient demonstrated a growth response of at least 2.5 centimeters per year?	

Growth Hormones

Phone: 215-991-4300
Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q62. Has the patient demonstrated a growth response of at least 4.5 centimeters per year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q63. Is the insulin-like growth factor (IGF)-1 concentration in the normal range for age and gender? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q64. Has the patient reached expected final adult height (mid-parental height)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q65. Does the patient have a diagnosis of Prader-Willi syndrome? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q68. Does the patient have a normal insulin-like growth factor (IGF)-1 concentration? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q69. Has the patient demonstrated any of the following since starting the requested medication: A) Weight stabilization or B) Weight increase? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q70. Additional Information:	



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Growth Hormones

Phone: 215-991-4300

Fax back to: 866-240-3712

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.

Member Name:	Prescriber Name:

Prescriber Signature

Date

v2025