Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _______________________

Physician Fax #: ____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Growth Hormone (GH) Therapy – Medical Necessity Request

****Please complete pages 1 and 2 for New/Initial requests****

General Information

Current Ht*: ___________inches or _________cm Date: _________
Current Wt: ________ lbs or _______kg Date: _________
* For Pediatric Patients, please provide most recent growth chart.

Height Standard Deviation: __________

GH Stimulation Test(s):
Stimulated with: __________________ Date: ______________
Stimulated with: __________________ Date: ______________
Stimulated with: __________________ Date: ______________

IGF-1: Below normal? **Yes or No** Percentile: _______
IGFBP3: Below normal? **Yes or No** Percentile: _______

Please provide documentation for all lab/test values
****If GH Stimulation tests were conducted sequentially on the same date, please document on lab when each stimulant was given****
GH Stimulation Test not required for members who have an anatomical absence of the pituitary

Is the member being managed by an Endocrinologist? **Yes or No**

Contraindication Information

Does member have any of the following:

- Active malignancy?
  Yes or No
- Active Proliferative or severe non-proliferative diabetic retinopathy?
  Yes or No
- Closed epiphyses or epiphyseal fusion?
  Yes or No
- Acute critical illness due to complications following open heart surgery, abdominal surgery, multiple accidental trauma or acute respiratory failure? **Yes or No**

Diagnosis Information (please select diagnosis and provide requested information below the diagnosis):

□ **Pediatric GH deficiency, Isolated GH Deficiency, Pituitary Dwarfism, Hypopituitarism or Panhypopituitarism**

1. Does the member have an anatomical absence of the pituitary? **Yes or No**
2. Does the member have signs of multiple pituitary hormone deficiencies (MPHD)? **Yes or No**
3. Does the member have evidence of another pituitary hormone deficiency? **Yes or No**
4. Has the member has received treatment known to cause growth hormone deficiency (e.g., cranial irradiation)? **Yes or No**

*If all of the above were answered No, please answer the following questions:

1. Is the member's height more than 2 standard deviations (SD) below the population mean? **Yes or No**
2. Is the projected height > 1.5 SD below the mean midparental height (average of mother's and father's heights)? **Yes or No**
3. Does the member have a 1 year height velocity of > 2 SD below the mean? **Yes or No**
4. Does the member have a 2-year height velocity of > 1.5 SD below the mean? **Yes or No**
5. Has the member failed 2 growth hormone stimulation tests (i.e., Insulin Tolerance Test (ITT), Growth Hormone-Releasing Hormone (GHRH)+ arginine (ARG), glucagon, arginine (ARG) tests, clonidine, levodopa) with growth hormone levels less than 10 ng/mL? **Yes or No**
6. Has the member failed at least 1 growth hormone stimulation test with a growth hormone level less than 10 ng/mL (e.g., ITT, GHRH+ARG, glucagon or ARG tests, clonidine, levodopa) AND IGF-I and IGFBP3 levels are below normal? **Yes or No**

□ **Turner syndrome**

- Is the member between the ages of 2 and 19 years old? **Yes or No**
- Has diagnosis been confirmed by appropriate genetic testing? **Yes or No** **Please submit documentation*
- Is the member's height percentile is below the 5th percentile? **Yes or No**
- What is the member's height taken within the past 60 days? ____________inches OR __________cm

□ **Chronic renal insufficiency** ** Please submit documentation for all of the following questions*

- Is the member less than 20 years old? **Yes or No**
- What is the member's Glomerular Filtration Rate (GFR)? __________________
- Is the member on dialysis? **Yes or No**
- Does the member have short stature (defined by height more than 1.88 standard deviations (SD) below the population mean OR height for age is less than the 3rd percentile)? **Yes or No.** ** Growth charts with height from the past 60 days must be received.*
- Does the member have normal metabolic and nutritional status?
  - □ **Yes**
  - □ **No** – Are all growth-inhibiting metabolic derangements (e.g., acidosis, secondary hyperparathyroidism, undernutrition) being managed? **Yes or No**
- Has member undergone renal transplantation?
  - □ **No** □ **Yes** - Is the transplant failing? **Yes or No**

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

□ **Prader-Willi syndrome**

- Has diagnosis been confirmed by appropriate genetic testing? **Yes or No** **Please submit documentation*
- Is the member severely obese? **Yes or No**
- Does the member have severe respiratory impairment? **Yes or No**
- Does the member have a history of upper airway obstruction or sleep apnea? **Yes or No**

□ **Noonan Syndrome**

- Has diagnosis been confirmed by appropriate genetic testing? **Yes or No** **Please submit documentation*
- Is the member less than 20 years old? **Yes or No**

□ **SHOX (short stature homeobox-containing) deficiency**

- Has diagnosis been confirmed by appropriate genetic testing? **Yes or No** **Please submit documentation*
- Has the member experienced puberty? **Yes or No**

□ **Small for gestational age (including Russell-Silver variant of intrauterine growth retardation)**

- Birth Weight: ____________
- Gestational Age: _________
- Was birth weight or length 2 standard deviations (SD) or more below mean? **Yes or No**
- Was the birth weight or length below the 3rd percentile? **Yes or No**
- Has the member failed to catch-up on height by age 2 as defined by height less than 2.5 standard deviations (SD) below the mean? **Yes or No**

****Please submit documentation of growth charts plotted. ****

□ **Adult GH deficiency** – Please specify type of onset and answer associated questions.

□ Adult Onset **Please submit documentation for all of the following questions*

- How many deficient hormones does the member have? __________
- Does the member have a history of head injury, cranial irradiation, subarachnoid hemorrhage or hypothalamic disease? **Yes or No**

□ Childhood Onset

- Was the member diagnosed with growth hormone deficiency as a child? **Yes or No**
- How many deficient hormones does the member have? _________ **Please submit documentation*
- Has the member achieved final height? **Yes or No**
  - If Yes, was therapy stopped for at least 1 month and the member was re-tested? **Yes or No**
- Does the member have irreversible hypothalamic-pituitary structural lesions (including structural hypothalamic-pituitary disease, or central nervous system tumors)? **Yes or No** **Please submit documentation*
- Does the member have congenital/embryopathic defects? **Yes or No** **Please submit documentation*

□ **HIV/AIDS wasting syndrome**

- Does member have a confirmed diagnosis of HIV or AIDS Wasting Syndrome or cachexia? **Yes or No**
- Is member currently receiving and will continue to receive antiretroviral therapy? **Yes or No**
- Baseline pre-morbid weight: _________ lbs or ________kg. Date Measured: ________
- Has member tried and failed at least 2 non-invasive forms of nutritional therapy (e.g., nutritional supplements, megestrol acetate, dronabinol) and is otherwise candidates for assisted enteral/total parenteral nutrition?

  □ **Yes** - Please provide the names of the therapies: ____

  □ **No**
- How many weeks supply is being requested? ____
- How many weeks of previous therapy has the member received? ____
- Is the member being managed by an Infectious Disease or HIV/AIDS specialist? **Yes or No**

□ **Idiopathic short stature**

- Is growth rate unlikely to permit attainment of adult height in the normal range? **Yes or No**
- Does the member have a height at least 2.25 standard deviations below the mean? **Yes or No**
- Have other causes of short stature, including growth hormone deficiency, and familial short stature been excluded? **Yes or No**
- Is the member less than 20 years old? **Yes or No**

□ **Short bowel syndrome**

- Is member managed by a Gastroenterologist and/or Endocrinologist? **Yes or No**
- Is the member receiving specialized nutritional support? **Yes or No**
- How many week of therapy has the member previously received? __________

□ **Other (please specify):** ___________________________

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: ______________________________________

Physician Name: ___________________________ Physician Phone #: _________________________ Specialty: ___________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

__Complete pages 3 and 4 ONLY for Subsequent (Renewal) requests or for dosage changes**__**

General Information

Current Height: ________ Date Taken: _________ Previous Dose: ______________________________

Current Weight: ________ Date Taken: _________ New Dose: _________________________________

Requested Quantity: _________________________

Diagnosis Information (please select diagnosis and provide requested information below the diagnosis):

□ Pediatric GH deficiency, Isolated GH Deficiency, Pituitary Dwarfism, Hypopituitarism or Panhypopituitarism
- Has epiphyseal closure/fusion occurred? **Yes or No**
- Is the member's growth velocity greater than 2cm per year? **Yes or No**
  ** Documentation (e.g., office notes, growth charts) showing change in height during the past year must be received.*

□ Chronic renal insufficiency
- Has member undergone renal transplantation?
  - □ **Yes** - Is the transplant failing? **Yes or No**
  - □ **No**
- Has epiphyseal closure/fusion occurred? **Yes or No**
- Is the member less than 20 years old? **Yes or No**

□ Turner's syndrome
- Is member's bone age less than 14 years old? **Yes or No**
- Does member have a growth velocity of at least 2cm/year? **Yes or No** ** Documentation (e.g., office notes, growth charts) showing change in height during the past year must be received.*
- Is the member less than 20 years old? **Yes or No**
- Has epiphyseal closure/fusion occurred? **Yes or No**

□ Noonan Syndrome
- Has epiphyseal closure/fusion occurred? **Yes or No**
- Is the member less than 20 years old? **Yes or No**

□ SHOX (short stature homeobox-containing) deficiency
- Has epiphyseal closure/fusion occurred? **Yes or No**
- Has the member experienced puberty? **Yes or No**

□ Prader-Willi syndrome
- Has epiphyseal closure/fusion occurred? **Yes or No**

□ Short for gestational age
- Has epiphyseal closure/fusion occurred? **Yes or No**
- Is the growth velocity greater than 2 cm/year? **Yes or No** *(If yes, please provide documentation showing change in height during the past year)*

□ Adult GH deficiency **Please provide documentation of any of the below answered Yes*
- Are IGF-1 levels below or within the normal range? **Yes or No**
- Has there been an improvement in any of the following:
  - blood lipid levels? **Yes or No**
  - waist-to-hip ratio? **Yes or No**
  - body composition? **Yes or No**
  - quality of life? **Yes or No**
- Has there been a reduction of cardiovascular risk factors? **Yes or No**

□ Idiopathic short stature
- Has epiphyseal closure/fusion occurred? **Yes or No**
- Has the member had an adequate height gain over the past year? **Yes or No**
- Is the member less than 20 years old? **Yes or No**

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**.

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ____________________

□ HIV/AIDS wasting syndrome

- Is member currently receiving and will continue to receive antiretroviral therapy? **Yes or No**
- How many weeks of therapy are being requested? ______________________________

□ Other (please specify): _____________________