Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Growth Hormone Medications

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard
☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Genotropin
☐ Humatrope ***Cigna preferred***
☐ Norditropin Flexpro ***Cigna preferred for Employer group plans***
☐ Nutropin AQ
☐ Omnitrope
☐ Saizen
☐ Serostim
☐ Zomacton
☐ Zorbtive

Strength: Dose (mg/kg):

Frequency of administration: Patient's current weight: ICD10:

Is there documentation that your patient has contraindication per FDA label, or intolerance to any of the following? Check all that apply.
☐ Humatrope
☐ Genotropin
☐ Norditropin Flexpro
☐ Nutropin AQ
☐ Omnitrope
☐ Saizen
☐ Zomacton

***Please attach supportive documentation.

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Retail pharmacy
☐ Physician's office stock (billing on a medical claim form)
☐ Home Health / Home Infusion vendor
☐ Other (please specify):
**Cigna's nationally preferred specialty pharmacy

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Questions for Pediatric Patients (for adult patients, please see the bottom of page 2)

Please answer the following questions for all Growth Hormone requests in children (except those with Panhypopituitarism, whole body or cranial irradiations); then complete the applicable section below:
Has your patient been treated with growth hormone in the past? ☐ Yes ☐ No
If *yes*, what was your patient's pre-treatment age?
If *yes*, what date was growth hormone therapy started?

What was your patient's pre-treatment height? ___ cm
What was your patient's pre-treatment height velocity? ___ cm/year
Are your patient's epiphyses open? ☐ Yes ☐ No

☐ Current growth curve chart attached with fax request

Please indicate the diagnosis Growth Hormone is being requested for and answer additional questions as necessary.

☐ Cranial or whole body irradiation

☐ Panhypopituitarism (child)

Which of the following anterior pituitary hormones are absent in your patient? Please mark all that apply.

☐ Follicle Stimulating Hormone (FSH)
☐ Androcorticotropic Hormone
☐ Thyroid Stimulating Hormone (TSH)
☐ Luteinizing Hormone (LH)

Please attach chart notes with lab levels.

☐ Growth Hormone Deficiency in Children

Does your patient have any of the following?
☐ CNS pathology. Please check any options that apply:
☐ Hypoplasia of pituitary gland ☐ Empty sella syndrome ☐ Pituitary or hypothalamic tumors
☐ Craniofacial developmental defects ☐ Septo-optic dysplasia ☐ Interruption of pituitary stalk
☐ Multiple pituitary hormone deficiency (MPHD)
☐ Proven genetic defect affecting the growth hormone axis
☐ Growth hormone deficiency (for example, pituitary dwarfism)

Stimulation Tests *(Please note that only 1 stimulation test is required for children with CNS pathology, MPHD, or proven genetic defect affect growth hormone axis. Growth hormone deficiency, including pituitary dwarfism, requires 2 stimulation tests.):*

Please provide the following:
1. stimuli used: Clonidine, Glucagon, Insulin, L-arginine, Levodopa, Propranolol
2. lab value
3. date taken

Stimuli	Lab Value	Date Taken

Have other pituitary hormone deficiencies been ruled out or corrected (including thyroid, cortisol and sex hormones)? ☐ Yes ☐ No
Which hormones are being supplemented? ___________________________

☐ Small for Gestational Age

What was your patient's **gestational age** (in weeks) at time of birth? _________
What was your patient's **birth weight**? _________ (specify gm, kg, lbs)
What was your patient's **birth length**? _________
What was your patient's **height at age 2?** _________

☐ Growth Delay Secondary to Chronic Kidney Disease

Does your patient have stage 2 or greater CKD (or GFR less than or equal to 60 ml/min/1.73 m2)? ☐ Yes ☐ No

☐ Genetic Diseases

☐ Turner's Syndrome ☐ Prader-Willi Syndrome ☐ Noonan Syndrome ☐ SHOX gene deletion

Has the diagnosis been established or confirmed by genetic testing? ☐ Yes ☐ No

Questions for Adult Patients

☐ **AIDS Wasting (Serostim Only)**

What was your patient's **pre-illness baseline body weight**?

What was your patient's **pre-illness baseline BMI**?

What is your patient's **current body weight**?

What is your patient's **current body mass index**?

Has your patient had failure to treatment with, or contraindication or intolerance to appetite stimulants and/or other anabolic agents?
☐ Yes ☐ No If *yes*, please list which medications were tried: ___________________________________

Will your patient have continuous use of antiviral therapy? ☐ Yes ☐ No

Please attach chart notes.

☐ **Panhypopituitarism (adult)**

Which of the following anterior pituitary hormones are absent in your patient? Please mark all that apply.

☐ Follicle Stimulating Hormone (FSH)
☐ Androcorticotropic Hormone
☐ Thyroid Stimulating Hormone (TSH)
☐ Luteinizing Hormone (LH)

Please attach chart notes with lab values and details of hormonal replacement therapy.

☐ **Adult Growth Hormone Treatment**

Is your patient's growth hormone deficiency a result of documented **childhood** growth hormone deficiency? ☐ Yes ☐ No

Is your patient's growth hormone deficiency a result of any of the following conditions? (Mark all that apply)

☐ Destructive hypothalamic disease
☐ Destructive pituitary disease
☐ Radiation therapy
☐ Surgery (please provide details about the procedure) _________________________________
☐ Trauma (please provide details about the nature of trauma) _______________________________

Is your patient's growth hormone deficiency of an idiopathic etiology?
☐ Yes ☐ No

If idiopathic etiology, please provide the pretreatment IGF-1 level:
Lab value: ___________________ Lab Normal Range: ___________________ Date taken: _________

Stimulation Tests:

Please note that only 1 stimulation test is required for GHD of defined etiology. Idiopathic GHD requires 2 stimulation tests.

Please provide the following:

1. stimuli used: Clonidine, Glucagon, Insulin, L-arginine, Levodopa, Macimorelin, Arginine-GHRH*
2. for Macimorelin and Arginine-GHRH only: patient's BMI at time of test
3. type of test: polyclonal antibody (RIA), monoclonal antibody (IRMA)
4. lab value
5. date taken

*please note that Arginine-GHRH is currently unavailable, therefore historical use only

Please provide the test results:

Stimuli	BMI (if applicable)	Test Type	Lab Value	Date Taken

Have other pituitary hormone deficiencies (thyroid, cortisol and sex hormones) been ruled out or corrected? ☐ Yes ☐ No

Please attach chart notes with lab values.

☐ **Short Bowel Syndrome (Zorbtive Only)**

Will this medication be used with a special diet AND glutamine supplementation? ☐ Yes ☐ No

Is your patient currently dependant on intravenous parenteral nutrition? ☐ Yes ☐ No

Please attach chart notes supporting this request.

☐ **Other Diagnosis (please specify):**

Human growth hormone is FDA-approved for treatment of a limited number of conditions. The FDA has not approved the use of human growth hormone as therapy for anti-aging, longevity, cosmetic or performance enhancement. Federal law prohibits the dispensing of human growth hormone for non-approved purposes. A pharmacy's failure to comply with that law could result in significant criminal penalties to the pharmacy and its employees. Accordingly, a pharmacy may decline to dispense prescriptions for human growth hormone when written by physicians or other authorized prescribers who they believe may be involved in or affiliated with the fields of anti-aging, longevity, rejuvenation, cosmetic, performance enhancement or sports medicine.

Physician Must Complete this Section and Sign:
Please document the diagnoses:____

Prescriber Certification: *I certify that this medication is not being prescribed for anti-aging, cosmetic, or athletic performance. I further certify human growth hormone is being prescribed for the medical condition noted above and is medically necessary.*

Physician Signature: ______________________________________ **Date:** ____________________________

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:____ **Date:**____________________

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

"NDC number is required on the medical claims to confirm claim is payable for the drug Genotropin. The NDC number can be found on the drug packaging. In addition you may refer to the Crosswalk of HCPCS Codes Requiring NDC on Claims at the Cigna for Health Care Professionals website (CignaforHCP.com > Resources > Clinical Reimbursement Policies and Payment Policies >."

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