Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Human Growth Hormone - Omnitrope® (somatropin)
(Also, MD's office must call 877-456-6794 to receive Omnitrope Pen Device)

If approval criteria are met Neighborhood Health Plan of RI will authorize coverage of Omnitrope Human Growth Hormone. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Fax Number (866) 423-0945

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Patient Name:______________________ Member ID# :_________ Date of Request:____________

Date of Birth: _____/______/______ Pt. Weight in kg: ___________________

Provider Name: __________________________ Phone:________________

Provider Fax:__________________ Contact Person in Office: __________________

Indicate product being requested:

Omnitrope ®	☐		

Please give Directions for use: _______________________________________

	YES	NO
Is the prescriber an endocrinologist?	☐	☐

INDICATIONS FOR USE

	YES	NO
1. Patient has **growth failure associated with chronic renal insufficiency**	☐	☐
a) Patient is in renal failure (glomerular filtration rate below 70ml/min/1.73m^2	☐	☐
b) Patient is in good metabolic control and is able to maintain adequate nutritional intake	☐	☐
c) For patients in end stage renal disease with no hope for transplant will supplementation significantly improve quality of life?	☐	☐

	YES	NO
2. Patient is diagnosed as **small for gestational age (SGA)**	☐	☐
a) Patient has a birth weight and/or length that is at least 2 SDS below the mean for gestational age	☐	☐
b) Patient's height remains SDS ≤ -2 by two years of age	☐	☐

	YES	NO
3. Patient is diagnosed with **idiopathic short stature**	☐	☐
a) Pediatric patients demonstrate height SDS ≤ -2.25 and this is associated with growth rates that are unlikely to lead to adult height within the normal genetic potential	☐	☐
b) The prescribing physician is a *pediatric endocrinologist*	☐	☐
c) Diagnostic evaluation has excluded other causes of short stature	☐	☐

	YES	NO
4. Patient is diagnosed with **growth failure in a child due to lack of growth hormone secretion**	☐	☐
a) Patient has abnormally low values (<10ng/mL) of serum GH on two provocative tests	☐	☐
b) Patient's height is > 2.0 standard deviations below the mean height for normal children of the same age	☐	☐
c) Conditions that depress GH secretion have been ruled out in this patient (e.g. hypothyroidism, chronic nonendocrine disease, etc.)	☐	☐

	YES	NO
5. Patient has been diagnosed with **Turner's Syndrome**	☐	☐
a) Karyotype or fibroblast studies reveal chromosomal information consistent with the disease	☐	☐

YES NO

6. Patient has been diagnosed with **Prader-Willi Syndrome (PWS)**	☐	☐
a) There is chromosomal information consistent with the disease	☐	☐

7. Patient has been diagnosed with **AIDS wasting or cachexia**	☐	☐
a) Drug requested must be Serostim®	☐	☐
b) Patient must have had a previous trial with megestrol acetate (Megace®)	☐	☐
c) Patient must be taking concomitant antiviral therapy	☐	☐

8. Patient has been diagnosed with **somatropin deficiency in adults**	☐	☐
a) Patient has a biochemical diagnosis of somatropin deficiency syndrome, by means of a substandard response to a standard growth hormone stimulation test. This will not be required in patients with a known permanent pituitary dysfunction (i.e. trauma or surgery).	☐	☐
b) Adult onset patients have somatropin deficiency as a result of pituitary disease, hypothalamic disease, surgery, trauma, or radiation therapy	☐	☐
c) Adult patients with onset as children continue to require replacement for normal homeostasis rather than growth promotion	☐	☐

If this is a renewal, review of the past 6 months demonstrates:	YES	NO
Pediatric patients demonstrate a continued growth rate of greater than 2cm per year	☐	☐
For pediatric patients who are small for gestational age, the total treatment duration will not exceed a 2 year period	☐	☐
There is no indication of epiphyseal closure in pediatric patients being treated for growth promotion	☐	☐
For pediatric patients who have recently received a renal transplant, supplementation should continue until achievement of final adult height or epiphyseal closure	☐	☐
Patient continues to need growth hormone for physiological homeostasis	☐	☐

CONTRAINDICATIONS FOR USE	YES	NO
1. Patient does not meet criteria for approval	☐	☐
2. Patient has closed epiphyses.	☐	☐
3. Patient has sensitivity to benzyl alcohol.	☐	☐
4. Patient has evidence of tumor activity or active neoplasia.	☐	☐
5. Patient has sensitivity to m-cresol or glycerin and is receiving Humatrope®.	☐	☐

If patient meets criteria: Also, MD's office must call 877-456-6794 to receive Omnitrope Pen Device

- **Initial approval: 6 months** • **Renewal approval period: 6 months**

Information given on this form is accurate as of this date.

______________________________ ____________________

Prescriber's signature and NPI Date

References

1. Olin BR, ed. Drug Facts and Comparisons (Updated Monthly). Facts and Comparisons. St. Louis, 2003.
2. AACE clinical practice guidelines for growth hormone use in adults and children-2003 update. *Endocrine Practice* 2003;9(1):64-76.
3. Guidelines for the use of growth hormone in children with short stature: a report by the Drug and Therapeutics Committee of the Lawson Wilkins Pediatric Endocrine Society. *J Pediatr* 1995;127:857-67.
4. Vance ML, Mauras N. Growth hormone therapy in adults and children. *N Engl J Med* 1999;Oct 14:1206-16.
5. Haffner D, Schaefer F, Nissel R, et al. Effect of growth hormone treatment on the adult height of children with chronic renal failure. *N Engl J Med* 2000; 343:923-30.
6. Lee PA, Kendig JW, Kerrigan JR. Persistent short stature, other potential outcomes, and the effect of growth hormone treatment in children who are born small for gestational age. *Pediatrics* 2003;112:150-162.