

**FORWARDHEALTH  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL)  
FOR GROWTH HORMONE DRUGS**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs Instructions, F-11092A. Prescribers may refer to the Forms page of the ForwardHealth Portal at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms> for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Growth Hormone Drugs form signed and dated by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Prescribers and pharmacy providers may call Provider Services at 800-947-9627 with questions.

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**SECTION I – MEMBER INFORMATION**

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1. Name – Member (Last, First, Middle Initial)

2. Member ID Number

3. Date of Birth – Member

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**SECTION II – PRESCRIPTION INFORMATION**

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4. Drug Name

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name – Prescriber

10. Address – Prescriber (Street, City, State, Zip+4 Code)

11. Phone Number – Prescriber

12. National Provider Identifier (NPI) – Prescriber

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**SECTION III – CLINICAL INFORMATION**

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13. Diagnosis Code and Description

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Complete the appropriate section of this form:

- For PA requests for growth hormone drugs (except Serostim), complete Section III A only.
  - For PA requests for Serostim, complete Section III B only.
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**SECTION III A – CLINICAL INFORMATION FOR GROWTH HORMONE DRUGS (EXCEPT SEROSTIM)**

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14. Is the drug requested a preferred growth hormone drug?  Yes  No

If the drug is a non-preferred growth hormone drug, describe the reason for the request.

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15. Is the prescription for the growth hormone drug written by an endocrinologist or through an endocrinology consultation?  Yes  No

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16. Indicate whether or not growth hormone will be used for each of the following congenital conditions.

- |                                  |                              |                             |
|----------------------------------|------------------------------|-----------------------------|
| 1. Noonan syndrome               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Prader-Willi syndrome         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. SHOX gene deficiency disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Turner syndrome               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Note:** PA requests for medical conditions not listed above are not available through STAT-PA.

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17. If growth hormone will not be used for one of the congenital conditions listed in Element 16, indicate the medical condition that is being treated.

Providers are required to include detailed documentation of the medical work-up and testing used to determine the need for growth hormone treatment. Documentation must include the following, when applicable, based on the member's age:

- Detailed endocrinology and medical work-up, including medical problem list, current medication list, and medication history
- Height and weight measurements over time plotted on the most clinically appropriate growth chart(s) for age and gender, including growth velocity, growth percentiles, and Z-scores
- Copies of the most recent insulin-like growth factor-1 (IGF-1) and insulin-like growth factor-binding protein 3 (IGFBP-3) lab reports
- Bone age results
- Thyroid-stimulating hormone level
- Nutrition assessment
- Any other relevant testing, such as advanced imaging of the hypothalamic-pituitary region, if performed

For growth hormone renewal PA requests, providers should include copies of the most recent endocrinology clinic notes, clinically appropriate height and weight growth charts for age and gender, the most current IGF-1 and IGFBP-3 lab testing results, and the most current bone age, when applicable, based on the member's age.

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18. Indicate the member's most recent IGF-1 and IGFBP-3 lab values, including the date(s) taken.

IGF-1: \_\_\_\_\_ Date Taken: \_\_\_\_\_

IGFBP-3: \_\_\_\_\_ Date Taken: \_\_\_\_\_

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19. Does the member have a recent growth hormone stimulation test?  Yes  No

Indicate the type and results of the most recent growth hormone stimulation test.

- 1.  Arginine Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL
- 2.  Clonidine Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL
- 3.  Glucagon Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL
- 4.  Insulin Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL
- 5.  Macimorelin Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL
- 6.  Other: \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL
- 7.  Other: \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Peak response result \_\_\_\_\_ ng/mL

Growth hormone stimulation testing should be conducted after an overnight fast using a well-standardized protocol. Complete testing results must be submitted with the PA request. The testing results must include the type of stimulation test and the dose of stimulating agent, a copy of the medical notes during the entire testing procedure, vital signs, blood glucose levels, the time and results from each blood sample taken, and the provider interpretation of the testing results.

**SECTION III B – CLINICAL INFORMATION FOR SEROSTIM ONLY**

20. Does the member have a diagnosis of AIDS wasting disease or cachexia?  Yes  No

**SECTION IV – AUTHORIZED SIGNATURE**

21. SIGNATURE – Prescriber

22. Date Signed

**SECTION V – FOR PHARMACY PROVIDERS USING STAT-PA**

23. National Drug Code (11 Digits)

24. Days' Supply Requested (Up to 365 Days)

25. NPI

26. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.)

27. Place of Service

28. Assigned PA Number

29. Grant Date

30. Expiration Date

31. Number of Days Approved

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**SECTION VI – ADDITIONAL INFORMATION**

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32. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.

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