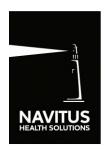
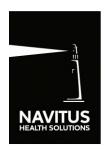


STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING		
Date:	Prescriber First & Last Name:	
Patient First & Last Name:	Prescriber NPI:	
Patient Address:	Prescriber Address:	
Patient ID:	Prescriber Phone:	
Patient Date of Birth:	Prescriber Fax:	
Medication Requested (Name):	Quantity Requested:	
Dose Requested:	Dosing Instructions:	
STEP 2: INDICATE PREFERRED PHARMACY		
☐ Driscoll Health Pharmacy (Phone: 361-694-420	0, Fax: 361-808-2792)	
☐ Maxor Pharmacy (Phone: 866-629-6779, Fax: 866-217-8034)		
☐ Premier Kids Care Pharmacy (Phone: 888-892-9001, Fax: 866-810-4021)		
☐ CVS/Pharmacy #2751 – Fort Worth, TX (Phone: 866-566-1548, Fax: 866-320-8853)		
☐ CVS/Pharmacy #2859 – San Antonio, TX (Phor	ne: 210-616-0080, Fax: 210-614-7859)	
☐ CVS/Pharmacy #2921 – Monroeville, PA (Phone: 800-238-7828, Fax: 877-287-7226)		
☐ InTouch Pharmacy (Phone: 877-874-5099, Fax: 706-534-6722)		
Goodsense Pharmacy (Phone: 210-802-2640; Fax: 210-802-2680)		
STEP 3: CLINICAL PRIOR AUTHORIZATION CRITERIA		
☐ Indicate Primary Diagnosis:	ICD-10 Code:	



1. Is the client 0 to 16 (greater than (>) 0 and less than or equal to (≤) 16) years of age?		
'-	_	<u> </u>
	Yes (Go to # 2)	☐ No (Go to # 13)
2.	Does the client have a diagnosis of growth horm	none deficiency (GHD) in the last 3 years?
	☐ Yes (Go to # 12)	☐ No (Go to # 3)
3.	3. Does the client have a diagnosis of panhypopituitarism in the last 3 years?	
	☐ Yes (Go to # 4)	☐ No (Go to # 5)
4.	Has the client had at least 2 claims for the reque	ested medication in the last 90 days (stable therapy)?
	☐ Yes (Go to # 17)	☐ No (Go to # 12)
5.	5. Does the client have a diagnosis of idiopathic short stature (ISS) in the last 3 years?	
	☐ Yes (Go to # 12)	☐ No (Go to # 6)
<ul> <li>6. Does the client have a diagnosis of ONE (1) of the following in the last 3 years?</li> <li>Short Stature Homeobox-Containing Gene (SHOX) Deficiency</li> <li>Turner Syndrome</li> <li>Noonan Syndrome</li> </ul>		
	☐ Yes (Go to # 17)	☐ No (Go to # 7)
7.	Does the client have a diagnosis of Prader-Willi	syndrome in the last 3 years?
	☐ Yes (Go to # 8)	☐ No (Go to # 10)
8.	8. Does the client have a diagnosis of obstructive sleep apnea in the last 365 days?	
	☐ Yes (Go to # 9)	☐ No (Go to # 17)
9. Does the client have a history of continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP) in the last 730 days?		
	☐ Yes (Go to # 17)	☐ No (Deny)
10. Does the client have a diagnosis of chronic kidney disease (CKD) in the last 3 years?		
	☐ Yes (Go to # 11)	☐ No (Deny)
11. Does the client have a history of a renal transplant (CPT) in the last 3 years?		
	☐ Yes (Deny)	☐ No (Go to # 12)



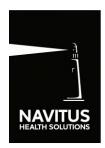
12. Does the submitted documentation support the requested diagnosis? [Manual Step]	
NOTE: For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months.	
☐ Yes (Go to # 17)	☐ No (Deny)
13. Does the client have a diagnosis of panhypopituitarism in the last 3 years?	
☐ Yes (Go to # 15)	☐ No (Go to # 14)
14. Does the client have a diagnosis of growth hormone deficiency (GHD) or idiopathic short stature (ISS) in the last 3 years?	
☐ Yes (Go to # 16)	☐ No (Deny)
15. Has the client had at least 2 claims for the requested medication in the last 90 days (stable therapy)?	
☐ Yes (Go to # 17)	☐ No (Go to # 16)
16. Does the submitted documentation support the requested diagnosis? [Manual Step]	
NOTE: For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months.	
·	•
·	•
requests, documentation must be from within th	e past 6 months.
requests, documentation must be from within th	e past 6 months.
requests, documentation must be from within th  Tes (Go to # 17)  17. Does the client have a diagnosis of active malig	e past 6 months.  No (Deny)  nancy in the last 180 days?  No (Go to # 18)
requests, documentation must be from within the  Yes (Go to # 17)  17. Does the client have a diagnosis of active malig	e past 6 months.  No (Deny)  nancy in the last 180 days?  No (Go to # 18)
requests, documentation must be from within the  Yes (Go to # 17)  17. Does the client have a diagnosis of active malig  Yes (Deny)  18. Does the client have a history of chemotherapy.  Yes (Deny)	e past 6 months.  ☐ No (Deny)  nancy in the last 180 days?  ☐ No (Go to # 18)  /radiation (CPTs) in the last 180 days?
requests, documentation must be from within the Yes (Go to # 17)  17. Does the client have a diagnosis of active maligurable Yes (Deny)  18. Does the client have a history of chemotherapy.  Yes (Deny)  19. Does the client have a diagnosis of active prolife.	e past 6 months.  No (Deny)  nancy in the last 180 days?  No (Go to # 18)  radiation (CPTs) in the last 180 days?  No (Go to # 19)
requests, documentation must be from within the Yes (Go to # 17)  17. Does the client have a diagnosis of active maligned Yes (Deny)  18. Does the client have a history of chemotherapy.  Yes (Deny)  19. Does the client have a diagnosis of active prolifering the last 365 days?	e past 6 months.  ☐ No (Deny)  nancy in the last 180 days?  ☐ No (Go to # 18)  /radiation (CPTs) in the last 180 days?  ☐ No (Go to # 19)  erative or severe non-proliferative diabetic retinopathy  ☐ No (Go to # 20)



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STEP 4: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553		
Prescriber Signature:	Date:	

If criteria not met, submit chart documentation with form citing complex medical circumstances. For questions, please call Navitus Customer Care at 1-877-908-6023.

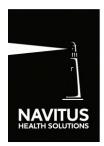


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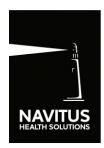
#### **GROWTH HORMONE QUICK REFERENCE GUIDE**

#### Testing Requirements for Clients ≤ 16 Years of Age

esting itequiren	nents for Clients ≤ 16 Years of Age	
Growth Hormone (Excluding Serostim and Zorbtive) Growth Hormone Deficiency, Idiopathic Short Stature, Panhypopituitarism, Chronic Kidney Disease, SHOX Deficiency, Turner Syndrome, Noonan Syndrome and Prader-Willi Syndrome in Children		
Diagnosis	<b>Testing Requirements:</b> For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months	
Panhypopituitarism	<ul> <li>Initiation of GH Therapy:         <ul> <li>IGF-1 level &lt; 160 ng/mL, AND</li> </ul> </li> <li>Failure to respond (response ≤ 5 ng/mL) to one growth hormone stimulation test (Note: children &lt; 12 months of age are excluded from provocative testing)</li> <li>Renewal of GH Therapy:         <ul> <li>No additional testing is required</li> </ul> </li> </ul>	
Growth Hormone Deficiency (GHD)	<ul> <li>Initiation of GH Therapy:         <ul> <li>Failure to respond (response &lt; 10 ng/mL) to at least 2 growth hormone stimulation tests (Note: children &lt; 12 months of age are excluded from provocative testing), AND</li> <li>Patient's height &gt; 2.25 SD below the mean for age OR patient's height &gt; 2 SD below the midparental height percentile, AND</li> <li>Growth velocity &lt; 25th percentile for bone age</li> </ul> </li> <li>Renewal of GH Therapy:         <ul> <li>Patient's growth should exceed 2 cm/year, AND</li> <li>Epiphyses are open</li> </ul> </li> </ul>	
Idiopathic Short Stature (ISS)	<ul> <li>Initiation of GH Therapy:         <ul> <li>Height &gt; 2.25 SD below the mean for age, AND</li> <li>Predicted adult height &lt; 63 inches for males and &lt; 59 inches for females</li> </ul> </li> <li>Renewal of GH Therapy:         <ul> <li>Patient's growth should exceed 2 cm/year, OR show an increase in height velocity of 50%, OR an increase of at least 2.5 cm/year above the baseline height velocity, AND</li> </ul> </li> </ul>	



Chronic Kidney Disease	<ul> <li>Initiation of GH Therapy:         <ul> <li>GFR ≤ 75mL/min/1.73m², AND</li> </ul> </li> <li>Patient's height &gt; 2.25 SD below the mean for age OR patient's height &gt; 2 SD below the midparental height percentile OR patient's Z score &lt; -1.88, AND</li> <li>Pre-transplant</li> <li>Renewal of GH Therapy:         <ul> <li>Patient's growth should exceed 2 cm/year, AND</li> <li>Pre-transplant, AND</li> <li>Epiphyses are open</li> </ul> </li> </ul>
SHOX Deficiency, Turner Syndrome, Noonan Syndrome and Prader-Willi Syndrome	Diagnosis only is required, no additional testing is requested



#### **Driscoll Children's Health Plan Only**

#### **Testing Requirements for Clients > 16 Years of Age**

Growth Hormone (Excluding Serostim and Zorbtive) Panhypopituitarism, Growth Hormone Deficiency or Idiopathic Short Stature in patients > 16 years of age		
Diagnosis	<b>Testing Requirements:</b> For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months	
Panhypopituitarism	<ul> <li>Initiation of GH Therapy:         <ul> <li>IGF-1 level &lt; 160 ng/mL, AND</li> </ul> </li> <li>Failure to respond to one growth hormone stimulation test (response ≤ 5ng/mL)</li> <li>Renewal of GH Therapy:         <ul> <li>No additional testing is required</li> </ul> </li> </ul>	
Idiopathic Short Stature (ISS)	<ul> <li>Renewal of GH Therapy:</li> <li>If patient has been treated as a pediatric patient (≤ 16 years of age) and is requesting a refill, patient's growth should exceed 2 cm/year, AND</li> <li>Bone age &lt; 16 years, AND</li> <li>Epiphyses are open</li> </ul>	
Growth Hormone Deficiency (GHD) with no other pituitary deficiency	<ul> <li>Initiation of GH Therapy:         <ul> <li>IGF-1 level &lt; 160 ng/mL, AND</li> </ul> </li> <li>Failure to respond to two growth hormone stimulation tests (response ≤ 5ng/mL)</li> <li>Renewal of GH Therapy:         <ul> <li>No additional testing is required</li> </ul> </li> </ul>	