Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] Genotropin MiniQuick 0.2 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 0.4 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 0.6 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 0.8 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 1 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 1.2 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 1.4 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 1.6 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 1.8 mg/0.25 mL subcutaneous syringe [ ] Genotropin MiniQuick 2 mg/0.25 mL subcutaneous syringe
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____ (*Required)

[ ] No

Q3: What is the member diagnosis? (Check only one that apply)

[ ] Prader-Willi syndrome (PWS)

[ ] Pediatric growth hormone deficiency (PGHD)

[ ] Small for gestational age (SGA)

[ ] Turner syndrome (TS)

[ ] Noonan syndrome (NS)

[ ] Short stature or growth failure in short stature homeobox-containing gene (SHOX) deficiency

[ ] Growth failure with chronic renal insufficiency (GFCRI)

[ ] Idiopathic Short Stature (ISS)

[ ] Adult-onset growth hormone deficiency (AGHD)

[ ] IGHDA

[ ] Transition phase adolescent patient (TPAP)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Does the member have positive response to treatment (eg, increase in total LBM, decrease in fat mass)? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q5: Is the expected adult height attained? (Check only one that apply)

[ ] Yes

[ ] No (please provide documentation of expected adult height goal) _____(*Required)

Q6: Is monitoring as demonstrated by document within past 12month of IGF-1/somatomedin C level? (Check only one that apply)

[ ] Yes

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q7: Does the member have positive response to therapy (eg, increase in total lean body mass, exercise capacity or IGF-1 and IGFBP-3)? (Check only one that apply)

[ ] Yes (please specify the type of positive clinical response) _____ (*Required)

[ ] No (please provide medical justification for continuation of therapy) _____(*Required)

Q8: What is the member diagnosis? (Check only one that apply)

[ ] Prader-Willi syndrome (PWS)

[ ] Pediatric growth hormone deficiency (PGHD)

[ ] Small for gestational age (SGA)

[ ] Turner syndrome (TS)

[ ] Noonan syndrome (NS)

[ ] Short stature or growth failure in short stature homeobox-containing gene (SHOX) deficiency

[ ] Growth failure with chronic renal insufficiency (GFCRI)

[ ] Idiopathic Short Stature (ISS)

[ ] Adult-onset growth hormone deficiency (AGHD)

[ ] IGHDA

[ ] Transition phase adolescent patient (TPAP)

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q9: Is there less than 4 month with suspected growth deficiency based on clinical presentation (eg, persistent neonatal hypoglycemia, persistent/prolonged neonatal jaundice/elevated bilirubin, male infant with microgenitalia, midline anatomical defects, failure to thrive)? (Check only one that apply)

[ ] Yes (please specify) _____(*Required)

[ ] No

Q10: Does the member have a history of neonatal hypoglycemia associated with pituitary disease? (Check only one that apply)

[ ] Yes

[ ] No

Q11: Does the member have a diagnosis of panhypopituitarism? (Check only one that apply)

[ ] Yes

[ ] No

Q12: Is the PGHD diagnosis confirmed by height (utilizing age and gender growth charts related to height) documented by height more than 2.0SD below midparental height? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No

Q13: Does the member have more than 2.25SD below population mean (below 1.2 percentile for age and gender)? (Check only one that apply)

[ ] Yes

[ ] No

Q14: Is the growth velocity more than 2SD below mean for age and gender? (Check only one that apply)

[ ] Yes (please specify growth velocity)

[ ] No

Q15: Is the delayed skeletal maturation more than 2SD below mean for age and gender (eg, delayed more than 2years compared with chronological age)]? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q16: Is the member's small for gestational age diagnosis based on catchup growth failure in 1st 24 month of life using 0-36 month growth chart? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q17: Is the diagnosis confirmed by birth weight or length below 3rd percentile for gestational age (more than 2SD below population mean)? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q18: Does the height remains at or below 3rd percentile (more than 2SD below population mean)? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q19: Is the diagnosis of pediatric growth failure associated with turner syndrome with documentation in female with bone age less than 14 years? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q20: Is the member's height below 5th percentile on growth charts for age and gender? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q21: Is the pediatric growth failure diagnosis with short stature homeobox-containing gene deficiency confirmed by genetic testing? (Check only one that apply)

[ ] Yes (please specify relevant documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q22: Is the pediatric growth failure diagnosis associated with chronic renal insufficiency? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q23: Does the diagnostic evaluation excludes other causes associated with short stature (eg. GHD, chronic renal insufficiency), doc height at or below -2.25SD score below corresponding mean height for age and gender associated with growth rates unlikely to permit attainment of adult height in the normal range? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q24: Is there documentation of male with bone age less than 16 years or female with bone age less than 14 years? (Check only one that apply)

[ ] Yes (please provide documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q25: Does the member have diagnosis of AGHD with clinical records supporting diagnosis of childhood-onset GHD? (Check only one that apply)

[ ] Yes

[ ] No

Q26: Does the member have adult-onset GHD with clinical records documented hormone deficiency due to hypothalamic-pituitary diagnosis from organic causes? (Check only one that apply)

[ ] Yes

[ ] No

Q27: Does the member have diagnosis of adult-onset GHD with clinical records documented hormone deficiency due to hypothalamic-pituitary disease from known causes (eg, damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and patient has 1GH stim test (insulin tolerance test [ITT], glucagon, macimorelin) to confirm adult GHD with peak GH values ([ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin])? (Check only one that apply)

[ ] Yes

[ ] No

Q28: Does the member have documented deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IGF-1/somatomedinC below age and gender adjusted normal range as provided by physicians lab? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request)

Q29: Does the member have documented GHD after 2 GH stimulation tests (ITT, glucagon, macimorelin), with 2 corresponding peak GH values [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30, 45 , 60, 90 minutes after administration? (Check only one that apply)

[ ] Yes (please specify name of test, results and date conducted)
_____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q30: Has the member attained expected adult height or closed epiphyses on bone radiograph? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q31: Does the member have a documented high risk of GHD due to GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary disease, panhypopituitarism, or deficiency of 3 anterior pituitary hormones: ACTH, TSH, prolactin, FSH/LH), with IGF-1/somatomedin C below age and gender adjusted normal range as provided by physicians lab? (Check only one that apply)

[ ] Yes (please provide documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q32: Does the member have low IGF-1/somatomedin C and discontinued GH treatment for at least 1 month? (Check only one that apply)

[ ] Yes (please provide clinical rationale for the request) _____
(*Required)

[ ] No

Q33: Does the member have 1 GH stimulation test (ITT, glucagon, macimorelin) after discontinuation of treatment for at least 1month with peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin] or at low risk of severe GHD (eg due to isolated and/or idiopathic GHD) and discontinued GH treatment for at least 1 month? (Check only one that apply)

[ ] Yes (please provide documentation) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q34: Is the member at low risk of severe GHD (eg due to isolated and/or idiopathic GHD) and discontinued GH treatment for at least 1 month? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q35: Has the member had 1 GH stimulation test (ITT, glucagon, macimorelin) after discontinuation of treatment for at least 1month with corresponding peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q36: Is the requested medication prescribed by or in consultation with endocrinologist? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Q37: Is the requested medication prescribed by or in consultation with endocrinologist or nephrologist? (Check only one that apply)

[ ] Yes (please specify prescriber specialty)

[ ] No (please provide clinical rationale for the request) _____
(*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	