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

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 ***Cigna preferred***
☐ Humatrope
☐ Norditropin Flexpro
☐ Nutropin AQ
☐ Omnitrope ***Cigna preferred**
☐ Saizen
☐ Serostim
☐ Zomacton

Strength: Dose (mg/kg):

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

if requesting Humatrope, Norditropin Flexpro, Nutropin AQ, Saizen, or Zomacton) The covered alternatives are: Genotropin, Omnitrope [both of which require prior authorization]. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

(if requesting Humatrope, Norditropin Flexpro, Nutropin AQ, Saizen, or Zomacton) For Genotropin, per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work.
☐ The patient tried this alternative, but they did not tolerate it.
☐ The patient cannot try this alternative because of a contraindication to this drug.
☐ Other

(if requesting Humatrope, Norditropin Flexpro, Nutropin AQ, Saizen, or Zomacton) For Humatrope, per the information provided above, which of the following is true for your patient?
☐ The patient tried this alternative, but it didn't work well enough.
☐ The patient tried this alternative, but they did not tolerate it.
☐ The patient cannot try this alternative because of a contraindication to this drug.
☐ other

***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 (under 18 years of age)

****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request****

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."
☐ New start ☐ Continuation of therapy

(if continuation of therapy) Has the patient's height increased by at least 2 cm/year in the most recent year? ☐ Yes ☐ No

(if 12-17 years old) Are the bony epiphyses open? ☐ Yes ☐ No

Which applies to your patient's use of growth hormone?

☐ acute critical illness due to complications following surgery, multiple accidental trauma, or with acute respiratory failure
☐ aging (that is, antiaging), to improve functional status in an elderly patient, and somatopause
☐ athletic ability enhancement
☐ central precocious puberty (CPP)
☐ chronic fatigue syndrome
☐ chronic kidney disease (CKD)
☐ congenital adrenal hyperplasia (CAH)
☐ constitutional delay of growth and puberty (CDGP)
☐ corticosteroid-induced short stature
☐ fibromyalgia
☐ growth hormone deficiency (GHD)
☐ human immunodeficiency virus (HIV)-infected patients with alterations in body fat distribution
☐ infertility
☐ Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature)
☐ Noonan syndrome
☐ obesity
☐ osteoporosis
☐ Prader-Willi Syndrome
☐ Short stature homeobox-containing gene deficiency
☐ Small for gestational age (SGA) or with Intrauterine Growth Restriction Including Silver-Russell Syndrome
☐ Turner's syndrome
☐ Other (please specify:

(if CKD) Does your patient have EITHER a glomerular filtration rate less than 60 milliliters/minute OR is their renal function considered stage 2 or more advanced Chronic Kidney Disease? ☐ Yes ☐ No

(if CKD) Is this medication being prescribed by, or in consultation with, an endocrinologist or a nephrologist? ☐ Yes ☐ No

(if CKD) What is/was your patient's pretreatment height? Please include date measured.

(if CKD) What is/was your patient's pretreatment growth velocity? Please include dates used to calculate.

(if CKD) Prior to treatment with growth hormone, did your patient meet any of the following:
☐ Baseline height is less than the 5th percentile for age and gender
☐ Individual's 6 to 12 month height velocity is more than two standard deviations (SD) below the mean for age and sex
☐ Individual's height velocity is more than 1.5 standard deviations (SD) below the mean sustained over two years
☐ None of the above

(if Noonan, Prader-Willi, Short Stature Homeobox-Containing Gene Deficiency, or Turner's) Has your patient's diagnosis been confirmed by genetic testing? ☐ Yes ☐ No

(if Noonan Syndrome NOT confirmed by genetic testing) Has the prescriber made a clinical diagnosis of Noonan syndrome (examples of clinical diagnosis include abnormal facial features [high forehead, epicanthic folds, etc.], pulmonary valve stenosis and/or hypertrophic cardiomyopathy, first-degree relative with Noonan syndrome, mild developmental delay)? ☐ Yes ☐ No

(if Short Stature Homeobox-Containing Gene Deficiency) Are the bony epiphyses open? ☐ Yes ☐ No

(if Noonan Syndrome or Short Stature Homeobox-Containing Gene Deficiency) What is/was your patient's pretreatment height? Please include date measured.

(if Noonan Syndrome or Short Stature Homeobox-Containing Gene Deficiency) What is/was your patient's pretreatment growth velocity? Please include dates used to calculate.

(if Noonan Syndrome or Short Stature Homeobox-Containing Gene Deficiency) Prior to treatment with growth hormone, did your patient meet any of the following:
☐ Baseline height is less than the 5th percentile for age and gender
☐ Individual's 1 year height velocity is more than two standard deviations (SD) below the mean for age and sex
☐ Individual's height velocity is more than 1.5 standard deviations (SD) below the mean sustained over two years
☐ None of the above

(if Turner Syndrome) What is/was your patient's pretreatment height? Please include date measured.

(if Turner Syndrome) What is/was your patient's pretreatment growth velocity? Please include dates used to calculate.

(if Turner Syndrome) Prior to treatment with growth hormone, did your patient meet any of the following?
☐ Baseline height is less than the 5th percentile for age and gender
☐ Individual's 1 year height velocity is more than two standard deviations (SD) below the mean for age and sex
☐ Individual's height velocity is more than 1.5 standard deviations (SD) below the mean sustained over two years
☐] None of the above

(if SGA/IUGR, including Silver-Russell Syndrome) What was your patient’s gestational age at birth?

(if SGA IUGR, including Silver-Russell Syndrome) What was the patient’s birth weight?

(if SGA IUGR, including Silver-Russell Syndrome) What was your patient’s birth length?

(if SGA/IUGR, including Silver-Russell Syndrome) What were your patient's height(s) at ages 2 to 4? If currently, less than 2 years of age, answer "less than 2 years."

(if SGA/IUGR including Silver-Russell Syndrome) Did your patient have either a birth weight or length that is greater than two standard deviations (SD) below the mean (less than -2 SD) for gestational age and gender? ☐ Yes ☐ No

(if SGA/IUGR including Silver-Russell Syndrome) Is the patient's baseline height less than the 5th percentile for age and gender? ☐ Yes ☐ No

(if GHD) Does your patient have or meet any of the following?
☐ Congenital hypopituitarism
☐ Defined central nervous system (CNS) pathology (for example, empty sella syndrome, interruption of pituitary stalk, hypoplasia of the pituitary gland, craniofacial developmental defects, pituitary or hypothalamic tumors OR has undergone tumor resection
☐ Documentation of Cranial or Whole Body irradiation
☐ Hypophysectomy (surgical removal of pituitary gland)
☐ Multiple pituitary hormone deficiencies
☐ Growth hormone deficiency of defined etiology in a transition adolescent
☐ Growth hormone deficiency (GHD) in a child or adolescent not otherwise specified

(if defined CNS pathology OR tumor resection) Does the patient have a deficiency in at least one other pituitary hormone (for example, adrenocorticotropic hormone, thyroid-stimulating hormone, gonadotropin [luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency], or prolactin)? ☐ Yes ☐ No

(if no other pituitary hormone deficiency) Has your patient's GHD been confirmed by stimulation testing? ☐ Yes ☐ No

(if confirmed by stim testing) Stimulation test #1 - please provide stimulus used (arginine, clonidine, glucagon, insulin-induced hypoglycemia, levodopa), date of test and the results.

(if confirmed by stim testing) Was the result of the required stim test less than 10 ng/mL? ☐ Yes ☐ No

(if multiple pituitary hormone deficiencies) Are at least 3 of the following pituitary hormones deficient in your patient: A. somatropin (growth hormone); B. adrenocorticotropic hormone (ACTH); C. thyroid-stimulating hormone (TSH); D. gonadotropin [luteinizing hormone (LH) and/or follicle stimulating hormone (FSH) are counted as one]; OR E. prolactin? ☐ Yes ☐ No

(if multiple pituitary hormone deficiencies) Has your patient had a growth hormone stimulation test? ☐ Yes ☐ No

(if stim test done) Stimulation test #1 - Please include agent used (levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon), date of test and results.

(if stim test done) Did the results of the required stim test show a growth hormone response of less than 10 ng/mL? ☐ Yes ☐ No

(if GHD of defined etiology in a transition adolescent) Does the individual have known perinatal insults OR congenital or genetic defects? ☐ Yes ☐ No

(if no perinatal insults OR congenital or genetic defects) Does the patient have three or more of the following pituitary hormone deficiencies: 1) adrenocorticotropic hormone, 2) thyroid-stimulation hormone, 3) gonadotropin deficiency (luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency), and 4) prolactin? ☐ Yes ☐ No

(if no perinatal insults OR congenital or genetic defects)) Please provide the pretreatment IGF-1 level, including date drawn and normal range of lab.

(if no perinatal insults OR congenital or genetic defects) Is the patient's age and gender adjusted serum insulin-like growth factor-1 below the lower limit of the normal reference range for the reporting laboratory? ☐ Yes ☐ No

(if no perinatal insults OR congenital or genetic defects) Have other causes of low serum insulin-like growth factor-1 have been excluded (for example, malnutrition, prolonged fasting, poorly controlled diabetes mellitus, hypothyroidism, hepatic insufficiency, oral estrogen therapy)? ☐ Yes ☐ No

(if GHD of defined etiology) Is somatropin being prescribed for anti-aging therapy or to enhance athletic ability or for body building? ☐ Yes ☐ No

(if GHD in a child or adolescent not otherwise specified) Has your patient's GHD been confirmed by stimulation testing? ☐ Yes ☐ No

(if confirmed by stim testing) Stimulation test #1 - please provide stimulus used (levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon), date of test and the results.

(if confirmed by stim testing) Stimulation test #2 - please provide stimulus used (levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon), date of test and the results. If the patient did not complete a second stimulation test, please indicate "none."

(if confirmed by stim testing) Did the patient have TWO stim test results that were less than 10 ng/mL? ☐ Yes ☐ No

(if GHD in a child or adolescent not otherwise specified) Had other pituitary hormone deficiencies been ruled out and/or corrected prior to the stimulation tests (for example, thyroid, cortisol, and sex steroids)? ☐ Yes ☐ No

(if yes) Which hormones are being supplemented?

(if GHD in a child or adolescent not otherwise specified) What is/was your patient's pretreatment height? Please include date measured.

(if GHD in a child or adolescent not otherwise specified) What is/was your patient's pretreatment growth velocity? Please include dates used to calculate.

(if GHD in a child or adolescent not otherwise specified) Prior to treatment with growth hormone, did your patient meet any of the following:

☐ Height is more than two standards of deviation (SD) below average for the population mean height for age and sex
☐ One-year height velocity is more than two standards of deviation (SD) below the mean for age and sex
☐ Height velocity is more than 1.5 standards of deviation (SD) below the mean sustained over two years
☐ None of the above

(if height is more than 2 SD below average for the population mean height for age and sex) Prior to treatment with growth hormone, do either of the following apply to your patient?

☐ One-year height velocity more than one standard deviation (SD) below the mean for chronological age
☐ Two years of age or older, and there is a decrease in height of more than 0.5 standards of deviation (SD) over one year
☐ None of the above

(if GHD, Noonan Syndrome, Prader-Willi Syndrome, Short Stature Homeobox-Containing Gene Deficiency, SGA/IUGR including Silver-Russel Syndrome) Is this medication being prescribed by, or in consultation with, an endocrinologist? ☐ Yes ☐ No

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) Does the patient have constitutional delay of growth and puberty? ☐ Yes ☐ No

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) Are the bony epiphyses open? ☐ Yes ☐ No

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) Without growth hormone therapy, is the individual's predicted adult height is less than 160 cm (63 inches) in males or less than 150 cm (59 inches) in females? ☐ Yes ☐ No

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) What is/was your patient's pretreatment height? Please include date measured.

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) Is the patient's baseline height less than or equal to 1.2 percentile or a standard deviation score (SDS) less than or equal to -2.25 for age and gender? ☐ Yes ☐ No

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) What is/was your patient's growth (height) velocity? Please include dates used to calculate.

(if Non-Growth Hormone Deficient Short Stature [Idiopathic Short Stature]) Which of the follow best describes the patient's growth (height) velocity?
☐ Growth rate less than 4 cm/year
☐ Growth (height) velocity is less than the 10th percentile for age and gender based on at least 6 months of growth data
☐ None of the above

Questions for Adult Patients (18 years and older)

****This drug requires supportive documentation (chart notes, lab/test results, etc). Supportive documentation for all answers must be attached with this request****

Is this a new start or continuation of therapy with the requested medication? If patient has been taking samples, please pick "new start."

☐ New start ☐ Continuation of therapy

(if continuation of therapy) Is there documentation of a beneficial response to this medication? ☐ Yes ☐ No

(if no) Please provide support for continued use.

Which applies to your patient's use of growth hormone?

☐ acute critical illness due to complications following surgery, multiple accidental trauma, or with acute respiratory failure
☐ aging (that is, antiaging), to improve functional status in an elderly patient, and somatopause
☐ athletic ability enhancement
☐ central precocious puberty (CPP)
☐ chronic fatigue syndrome
☐ congenital adrenal hyperplasia (CAH)
☐ constitutional delay of growth and puberty (CDGP)
☐ corticosteroid-induced short stature
☐ fibromyalgia
☐ growth hormone deficiency of defined etiology
☐ human immunodeficiency virus (HIV)-infected patients with alterations in body fat distribution
☐ infertility
☐ obesity
☐ osteoporosis
☐ Prader-Willi Syndrome
☐ Turner Syndrome
☐ Wasting or Cachexia with Human Immunodeficiency Virus (HIV) infection (Serostim Only)
☐ Other (please specify:

(if Prader-Willi or Turner's) Has your patient's diagnosis been confirmed by genetic testing? ☐ Yes ☐ No

(if Turner Syndrome) What is/was your patient's pretreatment height? Please include date measured.

(if Turner Syndrome) What is/was your patient's pretreatment growth velocity? Please include dates used to calculate.

(if Turner Syndrome) Prior to treatment with growth hormone, did your patient meet any of the following?
☐ Baseline height is less than the 5th percentile for age and gender
☐ Individual's 1 year height velocity is more than two standard deviations (SD) below the mean for age and sex
☐ Individual's height velocity is more than 1.5 standard deviations (SD) below the mean sustained over two years
☐ None of the above

(if GHD of defined etiology in an adult) When was the onset of growth hormone deficiency documented?
☐ During adulthood (adult onset)
☐ During childhood (childhood onset)
☐ Unknown

(if during adulthood) Which of the following describes the cause of adult onset growth hormone deficiency in your patient?
☐ Cranial radiation therapy
☐ Growth hormone deficiency ALONE
☐ Hypothalamic disease
☐ Multiple hormone deficiencies (hypopituitarism) resulting from pituitary disease
☐ Pituitary surgery
☐ Subarachnoid hemorrhage
☐ Traumatic brain injury (TBI)
☐ Tumor treatment
☐ None of the above

(if GHD of defined etiology) Does the individual have known perinatal insults OR congenital or genetic defects? ☐ Yes ☐ No

(if no perinatal insults OR congenital or genetic defects) Does the patient have three or more of the following pituitary hormone deficiencies: 1) adrenocorticotropic hormone, 2) thyroid-stimulation hormone, 3) gonadotropin deficiency (luteinizing hormone and/or follicle stimulating hormone deficiency are counted as one deficiency), and 4) prolactin? ☐ Yes ☐ No

(if no perinatal insults OR congenital or genetic defects)) Please provide the pretreatment IGF-1 level, including date drawn and normal range of lab.

(if no perinatal insults OR congenital or genetic defects) Is the patient's age and gender adjusted serum insulin-like growth factor-1 below the lower limit of the normal reference range for the reporting laboratory? ☐ Yes ☐ No

(if no perinatal insults OR congenital or genetic defects) Have other causes of low serum insulin-like growth factor-1 have been excluded (for example, malnutrition, prolonged fasting, poorly controlled diabetes mellitus, hypothyroidism, hepatic insufficiency, oral estrogen therapy)? ☐ Yes ☐ No

(if no perinatal insults or congenital or genetic defects) Has standard growth hormone stimulation testing been done? ☐ Yes ☐ No

(if stim testing done and no perinatal insults or congenital or genetic defects) Please provide results of all stim tests. Please include stimulus used*, type of test (polyclonal antibody/RIA or monoclonal antibody/IRMA if stimulus is insulin, levodopa, clonidine, arginine, or glucagon), date of test, and results. *If macimorelin, then also provide patient's BMI at time of test.

(if stim testing done and no perinatal insults or congenital or genetic defects) Did the patient have a growth hormone response of less than 5 ng/mL when measured by polyclonal antibody (RIA) or less than 2.5 ng/mL when measured by monoclonal antibody (IRMA) to a standard growth hormone stimulation test with insulin, levodopa, clonidine, arginine, or glucagon? ☐ Yes ☐ No

(if no growth hormone response of less than 5 ng/mL by RIA or less than 2.5 ng/mL by IRMA) Did the patient have a standard growth hormone stimulation test done with macimorelin? ☐ Yes ☐ No

(if stim test done with macimorelin) Did the patient have a maximum serum growth hormone level observed after stimulation of less than 2.8 ng/mL for the 4 blood draws? ☐ Yes ☐ No

(if max serum growth hormone level was less than 2.8 ng/mL for the 4 blood draws) Does the patient have a body mass index (BMI) of less than or equal to 40 kg/m2? ☐ Yes ☐ No

(if GHD of defined etiology) Is somatropin being prescribed for anti-aging therapy or to enhance athletic ability or for body building? ☐ Yes ☐ No

(if GHD of defined etiology or Prader-Willi Syndrome) Is this medication being prescribed by, or in consultation with, an endocrinologist? ☐ Yes ☐ No

(if wasting/cachexia for Serostim only) Does your patient have a body mass index (BMI) of 20kg/m2 or lower? ☐ Yes ☐ No

(if no) Did your patient unintentionally lose 10% or more of their baseline body weight? ☐ Yes ☐ No

if no) Does your patient have a weight of less than 90%of the lower limit of ideal body weight (IBW)? ☐ Yes ☐ No

(if no) Please provide your patient's height, current weight and baseline weight.

(if wasting/cachexia for Serostim only) Has wasting or cachexia that is due to malabsorption, poor diet, opportunistic infection, or depression, and other causes been addressed prior to starting somatropin? ☐ Yes ☐ No

(if wasting/cachexia for Serostim only) Is the patient currently on antiretroviral therapy OR have they been on highly active antiretroviral treatment for at least 30 days before starting Serostim therapy? ☐ Yes ☐ No

(if yes) Will the patient continue antiretroviral therapy throughout the course of Serostim treatment? ☐ Yes ☐ No

(if wasting/cachexia for Serostim only) Is this medication to be used solely for the treatment of alterations in body fat distribution such as increased abdominal girth, lipodystrophy and excess abdominal fat or buffalo hump? ☐ Yes ☐ No

(if wasting/cachexia for Serostim only) The covered alternatives are appetite stimulants and/or other anabolic agents. For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced. For the alternatives NOT tried, please provide details why your patient can't try that drug.

Per the information provided above, which of the following is true for your patient in regards to the covered alternatives?
☐ The patient tried one of the alternatives, but it didn't work.
☐ The patient tried one of the alternatives, but they did not tolerate it.
☐ The patient cannot try one of these alternatives because of a contraindication to this drug.
☐ Other

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:_____

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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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