

# TEVTROPIN (MEDICARE DETERMINATION)

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross<sup>®</sup> BlueShield<sup>®</sup> of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

**When this form is complete, please fax to Caremark at 888-836-0730.**

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services?  Y  N
2. Does the patient have a diagnosis of HIV with wasting or cachexia?  
[If the answer to this question is yes, no further questions are required.]  Y  N
3. Does the patient have a diagnosis of short bowel syndrome?  
[If the answer to this question is yes, no further questions are required.]  Y  N
4. Is the patient less than 18 years of age, **or** 18 years of age or older with open epiphyses?  
[If the answer to this question is no, skip to question 31.]  Y  N
5. Is the patient currently undergoing treatment with recombinant growth hormone (GH)?  
[If the answer to this question is yes, skip to question 10.]  Y  N
6. Does the patient have a height more than 2 standard deviations below the mean for normal children of the same age (equivalent to less than 5<sup>th</sup> percentile for age)?  Y  N

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7. Does the patient have a predicted adult height that is more than 1.5 standard deviations below the mid-parental height?  Y  N
8. Has the patient experienced a poor growth velocity defined as more than 1 standard deviation below the mean from normal children of the same age (less than 5 cm per year)?  Y  N
9. Will the physician evaluate the patient's serum insulin-like growth factor (IGF-1) during the first three months of therapy to evaluate the close?  Y  N
10. Does the patient have closed or fused epiphyses?  Y  N
11. Does the patient have the diagnosis of Turner syndrome?  
[If the answer to this question is no, skip to question 25.]  Y  N
12. Does the patient have the diagnosis of Prader-Will Syndrome confirmed by appropriate genetic testing?  
[If the answer to this question is no, skip to question 16.]  Y  N
13. Is the patient severely obese?  Y  N
14. Does the patient have a history of severe respiratory impairment or sleep apnea?  Y  N
15. Will GH therapy be discontinued if the patient develops severe respiratory impairment while on therapy?  
[Skip to question 25.]  Y  N
16. Does the patient have the diagnosis of chronic renal insufficiency or chronic renal failure?  
[If the answer to this question is no, skip to question 18.]  Y  N
17. Has the patient received a renal transplant?  
[Skip to question 24.]  Y  N
18. At birth, was the patient small for gestational age (defined as more than 2 standard deviations below normal for height and weight)?  
[If the answer to this question is no, skip to question 20.]  Y  N
19. Did the patient demonstrate catch-up growth by age 2?  
[Skip to question 25.]  Y  N
20. Does the patient have the diagnosis of Noonan syndrome?  
[If the answer to this question is yes, skip to question 25.]  Y  N
21. Does the patient have the diagnosis of SHOX (short stature homeobox-containing gene) deficiency?  
[If the answer to this question is yes, skip to question 25.]  Y  N
22. Does the patient have a diagnosis of idiopathic short stature, for which diagnostic evaluation excludes other causes associated with short stature that should be observed or treated by other means?  
[If the answer to this question is yes, skip to question 25.]  Y  N

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23. Prior to initiation of therapy, did the patient have a delayed bone age for chronological age?  Y  N
24. Prior to initiation of therapy, had the patient failed at least two growth hormone (GH) stimulation tests? (Failure as defined by the individual stimulation test used.)  Y  N
25. Has the patient been evaluated for other causes of growth failure [e.g., drug induced (e.g., steroids) skeletal disorders, malabsorption, chronic systemic disease, thyroid deficiency, celiac disease]?  Y  N
26. Has the patient received at least six months of therapy through the CVS Caremark pharmacy benefit? On behalf of BlueCross Blue Shield of South Carolina, CVS Caremark assists in the administration of the program. CVS Caremark is an independent company that provides pharmacy benefits management.  
[If the answer to this question is no, no further questions are required.]  Y  N
27. Has the patient been evaluated for continuation of therapy (e.g., thyroid level, lipid level body composition measurements and bone densitometry)?  Y  N
28. Has the height of the patient increased in the past six months?  Y  N
29. Has the growth velocity of the patient improved since the initiation of growth hormone therapy?  Y  N
30. Has the physician evaluated the patient's serum insulin-like growth factor (GF-1) to confirm the appropriateness of continued therapy?  
[No further questions are required.]  Y  N
31. Does the patient have a diagnosis of adult-onset hypothalamic-pituitary disease? [If the answer to this question is yes, skip to question 33.]  Y  N
32. Does the patient have decreased hypothalamic-pituitary function due to any of the following?  
  - Pituitary tumor
  - Pituitary surgical damage
  - Trauma
  - Cranial irradiation
  - Documented structural lesions
  - Proven genetic causes Y  N  
[If the answer to this question is no, skip to question 35.]
33. Does the patient have a documented deficiency of three or more pituitary hormones?  
[If the answer to this question is no, skip to question 38.]  Y  N
34. Prior to the initiation of growth hormone therapy, does/did the patient have a normal insulin-like growth factor 1 (IGF-1) level?  
[Skip to question 41.]  Y  N
35. Does the patient have a documented childhood-onset growth hormone deficiency?  Y  N

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36. Does the patient have congenital/genetic growth hormone deficiency or multiple hormone deficiencies due to organic disease?  
[If the answer to this question is yes, skip to question 38.]  Y  N
37. Does the patient have a normal insulin-like growth factor 1 (IGF-1)?  
[If the answer to this question is yes, skip to question 39.]  Y  N
38. Has the patient failed one growth hormone (GH) stimulation test?  
[A failure is generally defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia.]  
[Skip to question 40.]  Y  N
39. Has the patient failed at least two growth hormone (GH) stimulation tests?  
[A failure is generally defined as a maximum peak of less than 5 mcg/L when measured by RIA (polyclonal antibody), less than 3.5 mcg/L when measured by IRMA (monoclonal antibody) or less than 3 mcg/L during hypoglycemia.]  Y  N
40. Has the patient been assessed for other endocrine disorders (e.g., thyroid deficiency)?  Y  N
41. Will the physician evaluate the patient's serum insulin-like growth factor 1 (IGF-1) during the first three months of therapy to evaluate the dose?  Y  N
42. Has the patient received at least six months of therapy through a Caremark pharmacy benefit?  
[If the answer to this question is no, no further questions are required.]  Y  N
43. Has the patient been monitored (e.g., thyroid level, lipid level, body composition measurements and bone densitometry) for continuation of therapy?  Y  N
44. Has the physician evaluated the patient's serum insulin-like growth factor 1 (IGF-1) to confirm the appropriateness of the dose?  Y  N
45. Has the patient had an improvement in symptoms (e.g., decreased in body fat, increased bone density, better endurance, less fatigue) and clinical features of growth hormone deficiency?  Y  N

**Comments:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>  	<b>Date:</b>  
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