CIGNA
Pharmacy Services
Phone: (800)244-6224
Fax: (800)390-9745

CIGNA HealthCare Prior Authorization Form
- Growth Hormone Medications -

Notice: Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.

PROVIDER INFORMATION			PATIENT INFORMATION		
* Provider 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 or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* CIGNA ID:		
Office Fax:			* Date Of Birth:		
* Is your fax machine kept in a secure location? Yes ☐ No ☐ * May we fax our response to your office? Yes ☐ No ☐			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

Medication requested:

Medication name: Strength: Dose (mg/kg):

Frequency of administration: Patient's current weight:

Where will this medication be obtained?

- ☐ CIGNA Tel-Drug *(CIGNA's nationally preferred specialty pharmacy)*
- ☐ Retail pharmacy
- ☐ Prescriber's office stock (billing on a medical claim form)
- ☐ Home Health / Home Infusion vendor
- ☐ Other (please specify):

Please specify the following:

Has this patient been treated with growth hormone in the past? ☐Yes ☐ No

If Yes, what was the patient's pre-treatment age?

If Yes, what date was growth hormone therapy started?

Questions for Pediatric Patients (for Adult patients, see page 4 of this form)

Has this patient been evaluated by an endocrinologist (initially and annually)? ☐ Yes ☐ No	Additional Details:
What was the patient's **pre-treatment height**?	Answer/Detail:
What was the patient's **pre-treatment height velocity**	Answer/Detail:
Are the patient's epiphyses open? ☐ Yes ☐ No	Additional Details:

☐	**Growth Hormone Deficiency in Children**	
Additional Question(s)	Does this patient have any of the following CNS pathology? Please check any options that apply: ☐ Hypoplasia of pituitary gland ☐ Empty sella syndrome ☐ Craniofacial developmental defects ☐ Septo-optic dysplasia ☐ Interruption of pituitary stalk ☐ Pituitary or hypothalamic tumors ☐ History of irradiation ☐ Multiple pituitary hormone deficiency ☐ Proven genetic defect affect growth hormone axis	Additional Details:
	Has this patient had a growth hormone response of less than 10ng/mL to at least TWO provocative stimuli? ☐ Yes ☐ No *Please note that only 1 stim test is required for children with CNS pathology.*	Answer/Detail:
	Which provocative stimuli tests were performed? Please specify the date and lab value of tests performed.	Additional Details:

	Stimuli	Lab Value	Date Taken
☐	Insulin		
☐	Levodopa		
☐	L-Arginine		
☐	Clonidine		
☐	Glucagon		

	Have other pituitary hormone deficiencies been ruled out or corrected (including thyroid, cortisol and sex hormones)? ☐ Yes ☐ No	Additional Details:
	Please attach growth curve charts and include all lab levels. These items are required for review of this request.	

☐	**Small for Gestational Age**	
Additional Question(s)	What was this patient's **gestational age**?	Answer/Detail:
	What was this patient's **birth weight**?	Answer/Detail:
	What was this patient's **birth length**?	Answer/Detail:
	What was this patient's **height at age 2?**	Answer/Detail:
	Please attach growth curve charts. These items are required for review of this request.	

☐	**Growth Delay Secondary to Chronic Kidney Disease**	
Additional Question(s)	Does this patient have renal function at stage 2 chronic kidney disease (or GFR from 60-89 ml/min/1.73m^2)? ☐ Yes ☐ No	Additional Details:
	Please attach growth curve charts. These items are required for review of this request.	

☐	**Turner's Syndrome**	
Additional Question(s)	Has the diagnosis of Turner's Syndrome been established by genetic testing? ☐ Yes ☐ No *Please note that documentation of genetic testing is required for review of this request.*	Additional Details:
	Please attach growth curve charts and documentation of genetic testing. These items are required for review of this request.	
☐	**Panhypopituitarism**	
Additional Question(s)	Which of the following anterior pituitary hormones are absent in this patient? Please mark all that apply. ☐ Luteinizing Hormone (LH) ☐ Follicle Stimulating Hormone (FSH) ☐ Thyroid Stimulating Hormone (TSH) ☐ Androcorticotropic Hormone	Additional Details:
	Which hormones are being supplemented?	Additional Details:
	Please attach chart notes with lab levels. These items are required for review of this request.	
☐	**Prader-Willi Syndrome**	
Additional Question(s)	Has the diagnosis of Prader-Willi Syndrome been confirmed by appropriate genetic testing? ☐ Yes ☐ No	Additional Details:
	Please attach growth curve charts and include all lab levels. These items are required for review of this request.	
☐	**Noonan Syndrome**	
Additional Question(s)	Has the diagnosis of Noonan's syndrome been established by genetic testing or in consultation with a geneticist? ☐ Yes ☐ No	Answer/Detail:
	Please attach growth curve charts. These items are required for review of this request.	
☐	**Other Diagnosis (please specify below)**	
Additional Question(s)	**What is the patient's diagnosis? (Check all that apply)** ☐ Crohn's disease ☐ Down Syndrome ☐ Idiopathic Short Stature of Unknown Origin ☐ Intrauterine Growth Restriction (IUGR) ☐ Juvenile Rheumatoid Arthritis ☐ Non-Growth Hormone Deficient Short Stature ☐ Osteogenesis imperfecta ☐ Precocious puberty ☐ Russell-Silver Syndrome ☐ Skeletal dysplasia, such as achondroplasia ☐ Other (please specify):	Additional Details:

Questions for Adult Patients

☐ **Adult Growth Hormone Deficiency**

Additional Question(s)

Has this patient been evaluated by an endocrinologist?
☐ Yes ☐ No

Additional Details:

Is this patient's growth hormone deficiency a result of documented **childhood** growth hormone deficiency?
☐ Yes ☐ No

Additional Details:

Is this patient's growth hormone deficiency a result of any of the following conditions? (Mark all that apply)
☐ Destructive hypothalamic disease
☐ Destructive pituitary disease
☐ Radiation therapy
☐ Surgery (please provide details about the procedure)
☐ Trauma (please provide details about the nature of trauma)

Additional Details:

Has this patient had a growth hormone response of less than 5ng/mL to at least ONE provocative stimulus?
☐ Yes ☐ No

Additional Details:

Which provocative stimuli tests were performed? Please specify the date and lab value of tests performed.

	Stimuli	Lab Value	Date Taken
☐	Insulin		
☐	Levodopa		
☐	L-Arginine		
☐	Clonidine		
☐	Glucagon		
☐	Arginine-GHRH		

Additional Details:

Have other pituitary hormone deficiencies (thyroid, cortisol and sex hormones) been ruled out or corrected?
☐ Yes ☐ No

Additional Details:

Please attach chart notes with lab values.
These items are required for review of this request.

☐ **Multiple Pituitary Hormone Deficiencies / Panhypopituitarism**

Additional Question(s)

Has this patient been evaluated by an endocrinologist?
☐ Yes ☐ No

Additional Details:

Which of the following anterior pituitary hormones are absent in this patient? Please mark all that apply.
☐ Luteinizing Hormone (LH)
☐ Follicle Stimulating Hormone (FSH)
☐ Thyroid Stimulating Hormone (TSH)
☐ Androcorticotropic Hormone

Additional Details:

Please attach chart notes with lab values and details of hormonal replacement therapy.
These items are required for review of this request.

☐	**AIDS Wasting (Serostim Only)**	
Additional Question(s)	What was the patient's **pre-treatment baseline body weight**?	Answer/Detail:
	What is the patient's **current body weight**?	Answer/Detail:
	What is the patient's **current body mass index**?	Answer/Detail:
	Has this patient had failure to treatment with, or contraindication or intolerance to appetite stimulants and/or other anabolic agents? (Please provide medication details in the Additional Details section.) ☐ Yes ☐ No	Additional Details:
	Will this patient have continuous use of antiviral therapy? ☐ Yes ☐ No	Additional Details:
	Please attach chart notes with lab values. These items are required for review of this request.	
☐	**Short Bowel Syndrome (Zorbtive Only)**	
Additional Question(s)	Will this medication be used with a special diet AND glutamine supplementation? ☐ Yes ☐ No	Additional Details:
	Is this patient dependant on intravenous parenteral nutrition? ☐ Yes ☐ No	Additional Details:
	Please attach chart notes supporting this request. These items are required for review of this request.	
☐	**Other Diagnosis (please specify below)**	
Additional Question(s)	**What is the patient's diagnosis? (Check all that apply)** ☐ Crohn's Disease ☐ Increased Athletic Performance ☐ Infertility ☐ Muscular Dystrophy ☐ Obesity ☐ Osteoporosis ☐ Somatopause ☐ Other (please specify):	Additional Details:

CIGNA HealthCare's coverage position on this and other medications may be viewed online at: http://www.cigna.com/customer_care/healthcare_professional/coverage_positions

Please fax completed form to (800)390-9745. Due to the clinical information required, requests for Growth Hormone medications cannot be accepted via phone.

Our standard response time for prescription drug coverage requests is 2-4 business days. If your request is urgent, it is important that you call Pharmacy Services to have the request expedited. View our formulary on line at http://www.cigna.com.

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