### Request Date

- [ ] Initial Request
- [ ] Subsequent Request

### Individual’s Name:

<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Individual’s Phone Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

### Insurance Identification Number:

### Primary Diagnosis:

<table>
<thead>
<tr>
<th>Diagnosis Code(s) (if known):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual’s Weight</td>
</tr>
<tr>
<td>(lbs)</td>
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</tbody>
</table>

### Ordering Provider Name & Specialty:

<table>
<thead>
<tr>
<th>Provider ID Number (if known):</th>
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</thead>
<tbody>
<tr>
<td>Provider ID Number (if known):</td>
</tr>
</tbody>
</table>

### Office Address:

### Contact Name and Office Phone Number:

### Office Fax Number:

### Servicing Provider Name & Specialty (If different than Ordering Provider):

<table>
<thead>
<tr>
<th>Provider ID Number (if known):</th>
</tr>
</thead>
</table>

### Office Address:

### Contact Name and Office Phone Number:

### Office Fax Number:

### Place of Service:

- [ ] Home
- [ ] Office
- [ ] Dialysis Center
- [ ] Outpatient Hospital
- [ ] Ambulatory Infusion
- [ ] Ambulatory Infusion Center
- [ ] Other:

### Drug Name/HCPCS Code (if known)

<table>
<thead>
<tr>
<th>Drug Name/HCPCS Code (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genotropin® J2941</td>
</tr>
<tr>
<td>Norditropin® J2941</td>
</tr>
<tr>
<td>Saizen J2941</td>
</tr>
<tr>
<td>Somatropin J2941</td>
</tr>
<tr>
<td>Zorbtive® J2941</td>
</tr>
<tr>
<td>Geref® Q0515</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

### Dose to be administered:

<table>
<thead>
<tr>
<th>Dose to be administered:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(mg/kg)</td>
</tr>
<tr>
<td>(Other)</td>
</tr>
</tbody>
</table>

### When did the individual first start this drug?

<table>
<thead>
<tr>
<th>Frequency (Days, Wks, Months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>/</td>
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</tbody>
</table>

### Duration:

<table>
<thead>
<tr>
<th>Start Date For This Request:</th>
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<tbody>
<tr>
<td>/</td>
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</tbody>
</table>

### Please check all that apply to the individual:

**Initial Authorization Only**

- [ ] Individual is under 18 years of age (Please check any of the following that apply)
  - [ ] Individual has Idiopathic growth hormone deficiency (GHD)
  - [ ] Individual has signs or symptoms of growth hormone deficiency
  - [ ] Individual’s growth velocity 2 standard deviations below age appropriate mean
  - [ ] Individual’s height is 2.25 standard deviations below the age appropriate mean
  - [ ] Individual has a subnormal response (less than 10 ng/ml) to any **TWO** of following standard Growth Hormone (GH) Stimulation tests
    - [ ] Arginine
    - [ ] Clonodine
    - [ ] Glucagons
    - [ ] Insulin induced hypoglycemia
    - [ ] L-dopa - Propranolol
    - [ ] Other
Individual has at least 2 other pituitary hormone deficiencies. For example, individual is on medications for at least 2 other pituitary hormone deficiencies such as thyroid replacement (e.g. Synthroid®) and steroid replacement (e.g. prednisone or cortisone).

- Individual’s insulin-like growth factor (IGF-1) measurement is below age-appropriate level
- Individual is neonate with hypoglycemia and clinical and hormone evidence of hypopituitarism (growth hormone level less than 10 ng/ml)
- Individual has had cranial irradiation and has documented evidence of IGF-1 measurement below age-appropriate level with normal thyroid function test results.
- Other hormone deficiencies

Please List deficiencies: ____________________

For Re-Authorization Only

- Individual is under 18 years of age. (Please check the following that apply):
  - Individual is currently in 1st year of treatment
    - Individual has demonstrated a doubling of pre-treatment growth rate
    - Individual has an increase in pretreatment growth rate of 3cm/year or more
    - Individual is 12 years of age or younger
    - Individual is over 12 years of age and one of the following:
      - There is an x-ray report with evidence that epiphyses have not yet closed
      - Prior documented hypopituitarism
      - The Sexual Maturity Rating (SMR, Tanner Stage) is less than or equal to 3
  - Other ____________________

- Individual is currently past the 1st year of treatment.
  - Individual’s growth rate is above 2.5 cm/year
    - Individual is 12 years of age or younger
    - Individual is over 12 years of age
    - There is an x-ray report with evidence that epiphyses have not yet fused
    - Prior documented hypopituitarism
    - The Sexual Maturity Rating (SMR, Tanner Stage) is less than or equal to 3
  - Other ____________________

(2) Reconstructive Therapy Initial Request and Reauthorization

- Individual is under 18 years of age (Please check any of the following that apply):
  - Individual’s mean height is at least 2.25 but less than 2.5 standard deviations below the mean for age and gender
  - Individual’s growth velocity is less than 10th percentile over 1 year
  - Individual’s condition is known to be responsive to GH therapy (Please check any of the following that apply):
    - Chronic renal insufficiency
    - Prader-Willi Syndrome
      - (with BMI less than 35)
    - Noonan Syndrome
    - Turner Syndrome
    - Individual has Short Stature Homeobox (SHOX) gene
    - Individual was born small for gestational age defined (Please check all of the following that apply):
      - Birth weight or length was 2 or more standard deviations below the mean for gestational age (infants with intrauterine growth restriction or Russell-Silver Syndrome resulting in SGA are included in this category)
      - Individual has failed to manifest catch up growth before 4 years of age
      - (height is 2 or more standard deviations below the mean for age and sex)
      - Other causes for short stature such as growth inhibiting medication, chronic disease, endocrine disorders, and emotional deprivation or syndromes (except for Russell-Silver Syndrome) have been ruled out
  - Other ____________________

Please check any of the following that apply:

- Bone age is less than 16 years (male), or less than 14 years (female)
- Epiphyseal fusion has not occurred
- Mid-parental height has not been achieved. [(father’s height + mother’s height) divided by 2, plus 2.5 inches (male) or minus 2.5 inches (female)].

(3) Hormone Therapy in Adolescents and Young Adults

- Individual is 21 years of age or younger
- Individual had a documented GH deficiency in childhood with a growth rate of less than 2cm per year

- Individual has idiopathic isolated GHD (Growth Hormone Deficiency)
  - Growth hormone treatment stopped for at least 1 month and the diagnosis of GHD has been reconfirmed
  - Individual with a subnormal response (GH concentration of less than 10 ng/ml) to any 1 of following provocative tests:
    - Arginine
    - Clonidine
    - Glucagon
    - L-dopa
    - Propranolol
  - Individual has a low IGF-I/IGFBP-3
  - There is a subnormal response (GH concentration of less than 10 ng/ml) to 2 standard GH stimulation tests:
Individual has multiple pituitary hormone deficiencies

- Growth hormone treatment stopped for at least 1 month and the diagnosis of GHD has been reconfirmed
- There is a subnormal response (GH concentration of less than 10 ng/ml) to 1 provocative test

Individual has low IGF-II/IGFBP-3

Individual has had cranial irradiation with continued documentation of IGF-1 measurement below age-appropriate level with normal thyroid function test results

Individual has a known genetic mutation associated with deficient growth hormone production or secretion

Individual has a hypothalamic-pituitary tumor or structural defect

Individual has presence of at least 3 other pituitary hormone deficiencies. For example, individual is on medications for at least 3 other pituitary hormone deficiencies such as thyroid replacement (e.g. Synthroid®), steroid replacement (e.g. prednisone or cortisone), and hormone replacement (e.g. estrogen or testosterone)

Other hormone deficiencies:

**Please List deficiencies:**

(4) Growth Hormone Deficiency in Adults

- Individual is over 18 years of age. (Please check the following that apply):
  - Individual has one of the following conditions:
    - Documented GHD in childhood
    - Documented hypopituitarism as result of pituitary disease, hypothalamic disease, surgery, radiation therapy, trauma or aneurysmal subarachnoid hemorrhage
  - Individual had a subnormal response in adults to 2 standard growth hormone stimulation tests:
    - The Arginine serum GH concentration is less than or equal to 4.1 ng/ml
    - There is insulin induced hypoglycemia. (Serum GH concentration is less than or equal to 5 ng/ml)
    - Other
  - Individual had a subnormal response to 1 standard GH stimulation test
  - Individual has one or more additional pituitary hormone deficiencies
  - Individual has at least 3 other pituitary hormone deficiencies. For example, individual is on medications for at least 3 other pituitary hormone deficiencies such as thyroid replacement (e.g. Synthroid®), steroid replacement (e.g. prednisone or cortisone), and hormone replacement (e.g. estrogen or testosterone)
  - Other hormone deficiencies

**Please List deficiencies:**

(5) Short Bowel Syndrome

- Individual is receiving specialized nutritional support
- Other

(6) AIDS Wasting Syndrome

- Individual has had more than 10% baseline weight loss that cannot be explained by concurrent illness other than HIV infection
- Individual will simultaneously be treated with antiviral therapy
- Other

(7) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

**Please List deficiencies:**

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

/ / Name & Title of Provider or Provider Representative Completing Form Date

& attestation (Please Print)*

*The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted
Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.