Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

Ngenla

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Pediatric growth hormone deficiency (including panhypopituitarism)
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #8*
4. Is the patient currently receiving growth hormone through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #8* ❑ Yes ❑ Unknown ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Pediatric Growth Hormone Deficiency - ***ACTION REQUIRED: For initial therapy requests, attach the laboratory reports or medical record documentation of the pretreatment provocative tests for growth hormone (GH), pretreatment insulin-like growth factor-1 (IGF-1) levels, and growth chart if applicable.***

5. Is the following information provided by the prescriber: a) Total duration of treatment (approximate duration is acceptable), b) Date of the last dose administered, c) Approving health plan/pharmacy benefit manager, d) Date of the prior authorization/approval, and e) Prior authorization approval letter? ***ACTION REQUIRED: If Yes, attach medical records.*** ❑ Yes ❑ No
6. What is the patient's current height? _____ cm
7. What is the date that growth hormone therapy was initiated? _____
8. Are epiphyses still open? ❑ Yes - confirmed by X-ray ❑ Yes - but X-ray is not available ❑ No
9. Is the patient growing at a rate of more than 2 cm/year? ***ACTION REQUIRED: If Yes, attach current growth chart showing growth velocity.*** *If Yes, no further questions.* ❑ Yes ❑ No

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10. Is there a clinical reason for the lack of efficacy? *Indicate below and no further questions.*
    - ❑ On treatment less than 1 year - *Indicate treatment duration*: _____
    - ❑ Nearing final adult height/in later stages of puberty
    - ❑ Other _____

11. Was the patient diagnosed with growth hormone (GH) deficiency as a neonate?
    ❑ Yes ❑ No *If No, skip to #13*

12. Are medical records available to support the diagnosis of neonatal growth hormone (GH) deficiency such as hypoglycemia with random GH level, evidence of multiple pituitary hormone deficiencies, magnetic resonance imaging (MRI) results, or chart notes? ***ACTION REQUIRED: If Yes, attach medical records.***
    ❑ Yes ❑ No *No further questions.*

13. Does the patient have 2 pretreatment pharmacologic provocative tests for growth hormone (GH)?
    ACTION REQUIRED: If Yes, attach laboratory report or medical record of pre-treatment provocative test results. ❑ Yes ❑ No *If No, skip to #15*

14. What is the peak level? _____ ng/ml *Skip to #18*

15. Does the patient have a pituitary or central nervous system (CNS) disorder? ❑ Yes ❑ No

16. What is the pituitary or central nervous system (CNS) disorder?
    - ❑ GH secretagogue receptor gene defect
    - ❑ GH receptor/post receptor defect
    - ❑ Agenesis of corpus callosum
    - ❑ Ectopic posterior pituitary
    - ❑ Pituitary stalk defect
    - ❑ Encephalocele
    - ❑ Anencephaly or prosencephaly
    - ❑ Vascular malformation
    - ❑ Surgery
    - ❑ Chemotherapy
    - ❑ CNS infarction (e.g., Sheehan's syndrome)
    - ❑ Head trauma/traumatic brain injury
    - ❑ Perinatal or postnatal trauma
    - ❑ Growth hormone gene defect
    - ❑ Optic nerve hypoplasia/septo-optic dysplasia
    - ❑ Empty sella syndrome
    - ❑ Pituitary aplasia/hypoplasia
    - ❑ Holoprosencephaly
    - ❑ Hydrocephalus
    - ❑ Arachnoid cyst
    - ❑ Cyst (Rathke cleft cyst or arachnoid cleft cyst)
    - ❑ Radiation
    - ❑ CNS infection
    - ❑ Inflammatory process (e.g., autoimmune hypophysitis)
    - ❑ Aneurysmal subarachnoid hemorrhage
    - ❑ Surgery of the pituitary or hypothalamus
    - ❑ Growth hormone releasing hormone (GHRH) receptor gene defect
    - ❑ Infiltrative process (e.g., sarcoidosis, histiocytosis, hemochromatosis)
    - ❑ Transcription factor defect (PIT-1, PROP-1, LHX3/4, HESX-1, PITX-2)
    - ❑ Other mid-line facial defects (e.g., single central incisor, cleft lip/palate)
    - ❑ CNS tumor/neoplasm (e.g., craniopharyngioma, glioma/astrocytoma, pituitary adenoma, germinoma)
    - ❑ Other _____

17. Does the patient have a pretreatment insulin-like growth factor-1 (IGF-1) level greater than 2 standard deviations (SD) below the mean based on the laboratory reference range? ***ACTION REQUIRED: If Yes, attach laboratory report or medical record of pretreatment IGF-1 level.*** ❑ Yes ❑ No

18. Is one pretreatment height and the patient's age at the time the height was recorded provided? Indicate height in centimeters and age in years and months. _____ ❑ Yes ❑ No

19. Is a second pretreatment height and the patient's age at the time the height was recorded provided? Indicate height in centimeters and age in years and months. _____ ❑ Yes ❑ No

20. Does the patient have a pretreatment height of greater than 2 standard deviations (SD) below the mean for age and gender? ❑ Yes ❑ No *If No, skip to #22*

21. Does the patient have a pretreatment 1-year height velocity of greater than 1 standard deviation (SD) below the mean for age and gender? ***ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment height and height velocity.*** ❑ Yes ❑ No *No further questions.*

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22. Does the patient have a pretreatment 1-year height velocity of greater than 2 standard deviations (SD) below the mean for age and gender? ***ACTION REQUIRED: If Yes, attach a growth chart showing pretreatment height velocity.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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