Growth Hormone drafted criteria
For Review by the Pharmacy and Therapeutics Committee
December 2016

Growth Hormone

Guideline note 74: Growth Hormone Treatment *-- Lines 44, 391, 473*
Treatment with growth hormone is included only for children with: pituitary dwarfism, Turner's syndrome, Prader-Willi-syndrome, Noonan's syndrome, short stature with homeobox-containing gene (SHOX), chronic kidney disease (stages 3, 4, 5 or 6) and those with renal transplant. Treatment with growth hormone should continue only until adult height as determined by bone age is achieved. Treatment is not included for isolated deficiency of human growth hormone or other conditions in adults.

Formulary option		
1. Is the member being treated for an OHP funded condition?	Yes: Move to #2	No: Category 1 denial
2. Is the medication for use for the promotion of growth in a child with 3rd degree burns? *Medication should be prescribed in consultation with a pediatric endocrinologist.*	No: Move to #3	Yes: Forward to MD for medical appropriateness evaluation. Length of therapy may vary.
3. Is the member an adult 19 years of age or older and achieved adult bone age confirmed by x-ray? *Per guideline note 74, this is not a funded condition on OHP*	No: Move to #4	Yes: Forward to MD for medical appropriateness denial. Per GN 74, GH treatment is not covered in adults.
4. Is this a request for initiation of growth hormone?	Yes: Move to #5	No: Go to renewal criteria
5. Is the prescriber a pediatric endocrinologist or a pediatric nephrologist?	Yes: Move to #6	No: Forward to MD for medical appropriateness (Category 5) evaluation
6. Is the diagnosis for one of the following • Turner's syndrome • Noonan's syndrome • Prader-Willi syndrome • Pituitary dwarfism • Short stature homeobox-containing gene (SHOX) • Chronic kidney disease (CKD, stage ≥ 3) • Renal Transplant	Yes: move to #7	No: Forward to MD for medical appropriateness (Category 5) evaluation

7. Is there evidence of non-closure of epiphyseal plate?	Yes: move to #8	No: forward to MD for medical appropriateness (Category 5) evaluation
8. Is the requested agent formulary, or is the member unable to use a formulary option? • Norditropin is preferred formulary option • Genotropin is formulary but not preferred option	Yes: approve of 12 months	No: Category 15 denial
Renewal Criteria		
1. Does medication continue to be used for an OHP funded condition?	Yes: Move to #2	No: Category 1 denial
2. Is growth velocity greater than 2.5cm per year?	Yes: Move to #3	No: forward to MD for medical appropriateness (Category 5) evaluation
3. Is there evidence of non-closure of epiphyseal plate?	Yes: Move to #4	No: Forward to MD for medical appropriateness (Category 5) evaluation
4. Does review of the claims history shows 80% or greater medication adherence to requested medication?	Yes: Move to #5	No: Amend authorization to 3 months with continuation requiring 80% or greater medication adherence.
5. Is the requested product on formulary, or is member unable to use formulary option? • Norditropin is preferred formulary option • Genotropin is formulary but not preferred option	Yes: Approved for up to 12 months	No: CPhT to reach out to provider and request change to formulary option—potential Category 15 denial.