Medication Request Form (MRF)
Growth Hormone
c/o MedImpact Healthcare Systems, Inc.

Please complete this form and FAX to:
MedImpact HealthCare Systems, Inc.
Attn: Prior Authorization Department
1-858-790-7100 FAX

Or to call in this information to:
MedImpact HealthCare Systems, Inc.
Attn: Prior Authorization Department
1-800-788-2949

Questions call:
MedImpact HealthCare Systems, Inc.
Attn: Customer Service Department
1-800-788-2949

Please complete the following information – REQUIRED – ALL WHITE BOXES (Those not highlighted in gray) MUST BE COMPLETED or the form will be returned to the sender. Please complete all boxes if possible.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Physician Name and Specialty:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient ID:</td>
<td>Physician DEA #:</td>
</tr>
<tr>
<td>Patient DOB:</td>
<td>Patient Phone #:</td>
</tr>
<tr>
<td>Diagnosis:</td>
<td>Physician Address, City, State, ZIP:</td>
</tr>
<tr>
<td>Drug Requested:</td>
<td>Physician Phone Number and Area Code: (   ) —</td>
</tr>
<tr>
<td>Dosage, Quantity Requested (per month) and Length of Treatment (please be specific):</td>
<td>Pharmacy Name, Phone Number and Area Code: (   ) —</td>
</tr>
</tbody>
</table>

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(Rev 12/05)
AIDS-RELATED CACHEXIA
1. Does the member have AIDS-related cachexia/wasting syndrome? (if yes, answer a to h below) ................................................................. ☐ Yes ☐ No
   a. 10% unintentional weight loss over 12 months .......................................................................................................................... ☐ Yes ☐ No
   b. 7.5% unintentional weight loss over 6 months .......................................................................................................................... ☐ Yes ☐ No
   c. 5% body cell mass (BCM) loss within 6 months ......................................................................................................................... ☐ Yes ☐ No
   d. In men: BCM < 35% of total body weight and body mass index (BMI) < 27kg/m² ................................................................. ☐ Yes ☐ No
   e. In women: BCM < 23% of total body weight and BMI < 27kg/m² ......................................................................................... ☐ Yes ☐ No
   f. Is member currently using antiretroviral therapy? ......................................................................................................................... ☐ Yes ☐ No
   g. Has the member tried and failed dronabinol, oxandrolone, or megestrol? .................................................................................. ☐ Yes ☐ No
   h. If this is a renewal, has the member experienced at least 0.5kg per month weight gain? ............................................................... ☐ Yes ☐ No

GROWTH HORMONE DEFICIENCY
PEDIATRICS (< 18 years of age)
2. Is the prescriber an endocrinologist or nephrologist? .......................................................................................................................... ☐ Yes ☐ No
   Does the member have one of the following diagnoses:
   a. Growth hormone deficiency ......................................................................................................................................................... ☐ Yes ☐ No
   b. Small for gestational age (birth weight < 2.5 kg at a gestational age of 37 weeks, or a birth length or weight below the 3rd percentile for gestational age) .......................................................................................................................... ☐ Yes ☐ No
      i. Has the child failed to manifest catch-up growth defined as a height at least -2 SD below the mean for children of the same age? .................................................................................................................................................. ☐ Yes ☐ No
   c. Pre-transplant chronic kidney disease ........................................................................................................................................... ☐ Yes ☐ No
      i. Is the child’s height more than -2 SD below the mean (<3rd percentile) compared to normal children of the same age? ................................................................................................................................................. ☐ Yes ☐ No
   d. Neonatal hypoglycemia associated with growth hormone deficiency ................................................................................................. ☐ Yes ☐ No
3. Does the member have a lack of response to growth hormone stimulation tests, or an IGF-1 that is –2 SD below the normal range for age and sex, or an IGFBP-3 level that is –2 SD below the normal range for age and sex? (Please fax documentation) ................................................................................................................................................. ☐ Yes ☐ No
4. Does member have a diagnosis of Turner’s syndrome or the SHOX mutation? (Please fax documentation) .......... ☐ Yes ☐ No
5. Does the member have Prader-Willi syndrome or Noonan syndrome? .............................................................................................................. ☐ Yes ☐ No
6. If this is a request for renewal of growth hormone therapy, has the member demonstrated a positive response to growth hormone therapy as evidenced by an increase in height, increase in growth velocity, or IGF-1 level normalization? ................................................................................................................................. ☐ Yes ☐ No
7. Does the radiograph of the wrist or hand show evidence of closure of the epiphyseal plate? (Please fax documentation) ........... ☐ Yes ☐ No

ADULTS (≥ 18 years of age)
8. Is the prescriber an endocrinologist? ......................................................................................................................................................... ☐ Yes ☐ No
9. Does the member have growth hormone deficiency that is from an organic cause (e.g., pituitary hormone deficiency)? ......................................................................................................................................................... ☐ Yes ☐ No
10. Does the member have growth hormone deficiency that is idiopathic in nature or related to a head injury (e.g., cranial irradiation, subarachnoid hemorrhage, or hypothalamic disease)? .................................................................................................................................................... ☐ Yes ☐ No
11. Has the member demonstrated a lack of response to growth hormone stimulation tests, or an IGF-1 that is –2 DS below the normal range for age and sex? (Please fax documentation) ................................................................................................. ☐ Yes ☐ No
12. If this request is for continued growth hormone treatment, has the member shown a clinical benefit from treatment through a normalization of IGF-1, improvement in body composition, or improvement in quality of life? ......................................................................................................................................................... ☐ Yes ☐ No

MedImpact HealthCare Systems, Inc.
10680 Treena Street, Suite 500
San Diego, CA 92131

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