



Request for Prior Authorization
GROWTH HORMONES

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for therapy with growth hormones. Requests will only be considered for FDA approved dosing. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Preferred

- Checkboxes for Norditropin, Nutropin AQ Pen, Nutropin AQ NuSpin

Non- Preferred

- Checkboxes for Genotropin, Humatrope, Omnitrope, Saizen, Tev-Tropin, Zorbtive

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Number of vials per month: Estimate length of therapy:

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges):

Reason for use of Non-Preferred drug requiring prior approval:

Children with Growth Hormone Deficiency

- 1. Standard deviation of 2.0 or more below mean height for chronological age; and
2. No expanding intracranial lesion or tumor diagnosed by MRI; and
3. Growth rate below five centimeters per year; and
4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter; and
5. Annual bone age testing is required. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
6. Epiphyses open.



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Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? [] Yes [] No
Height: _____ Weight: _____ Height percentile at time of diagnosis: _____ Weight percentile: _____
Is standard deviation 2.0 or more below mean height for chronological age? [] Yes [] No
MRI diagnosis: _____ Date: _____
Growth rate per year _____
Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far: _____

Please provide 2 stimuli tests and results:

[] Pediatric Chronic Kidney Disease

- 1. Is prescribed by or in consultation with a nephrologist; and
2. Standard deviation of 2.0 or more below mean height for chronological age; and
3. No expanding intracranial lesion or tumor diagnosed by MRI; and
4. Growth rate below five centimeters per year; and
5. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
6. Epiphyses open.

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? [] Yes [] No
Height: _____ Weight: _____ Height percentile at time of diagnosis: _____ Weight percentile: _____
Is standard deviation 2.0 or more below mean height for chronological age? [] Yes [] No
MRI diagnosis: _____ Date: _____
Growth rate per year _____
Is prescriber a nephrologist? [] Yes [] No If no, note consultation with nephrologist:
Consultation date: _____ Physician name & phone: _____

[] Turner's Syndrome

- 1. Chromosomal abnormality showing Turner's syndrome; and
2. Prescribed by or in consultation with an endocrinologist; and
3. Standard deviation of 2.0 or more below mean height for chronological age; and
4. No expanding intracranial lesion or tumor diagnosed by MRI; and
5. Growth rate below five centimeters per year; and
6. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
7. Epiphyses open.

Chromosomal abnormality showing Turner's syndrome? [] Yes (attach results) [] No
Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? [] Yes [] No
Height: _____ Weight: _____ Height percentile at time of diagnosis: _____ Weight percentile: _____
Is standard deviation 2.0 or more below mean height for chronological age? [] Yes [] No
MRI diagnosis: _____ Date: _____
Growth rate per year _____
Is prescriber an endocrinologist? [] Yes [] No If no, note consultation with endocrinologist:
Consultation date: _____ Physician name & phone: _____



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Prader Willi Syndrome

- 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
4. Epiphyses open.

Diagnosis confirmed by genetic testing? Yes (attach results) No
Bone Age: Date of Bone Age Test: Epiphyses open? Yes No

Is prescriber an endocrinologist? Yes No If no, note consultation with endocrinologist:

Consultation date: Physician name & phone:

Noonan Syndrome

- 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. Standard deviation of 2.0 or more below mean height for chronological age; and
4. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
5. Epiphyses open.

Diagnosis confirmed by genetic testing? Yes (attach results) No
Bone Age: Date of Bone Age Test: Epiphyses open? Yes No

Is prescriber an endocrinologist? Yes No If no, note consultation with endocrinologist:

Consultation date: Physician name & phone:

Height: Weight: Height percentile at time of diagnosis: Weight percentile:
Is standard deviation 2.0 or more below mean height for chronological age? Yes No

SHOX (Short Stature Homeobox)

- 1. Diagnosis is confirmed by appropriate genetic testing (attach results); and
2. Prescribed by or in consultation with an endocrinologist; and
3. A bone age 14 to 15 years or less in females and 15 to 16 years or less in males is required; and
4. Epiphyses open.

Diagnosis confirmed by genetic testing? Yes (attach results) No
Bone Age: Date of Bone Age Test: Epiphyses open? Yes No

Is prescriber an endocrinologist? Yes No If no, note consultation with endocrinologist:

Consultation date: Physician name & phone:



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Adults with Growth Hormone Deficiency

- 1. Patients who were growth hormone deficient during childhood (childhood onset) and who have continued deficiency; or
2. Patients who have growth hormone deficiency (adult onset) as a result of pituitary or hypothalamic disease (e.g. panhypopituitarism, pituitary adenoma, trauma, cranial irradiation, pituitary surgery); and
3. Failure of at least one growth hormone stimulation test as an adult with a peak growth hormone value of <= 5 mcg/L after stimulation.

- o Childhood Onset
o Adult Onset: provide pituitary or hypothalamic disease diagnosis: _____

Please provide stimuli test, date and result: _____

Adults with AIDS Wasting/Cachexia

- 1. Greater than 10% of baseline weight loss over 12 months that cannot be explained by a concurrent illness other than HIV infection; and
2. Patient is currently being treated with antiviral agents; and
3. Patient has documentation of a previous trial and therapy failure with an appetite stimulant (i.e. dronabinol or megestrol).

Has patient experienced > 10% weight loss over 12 months?

Yes Baseline weight & date: _____ Current weight & date: _____ No

Does patient have concurrent illness other than HIV infection contributing to weight loss? Yes No

Current antiviral treatment: Drug name, dosing & trial dates: _____

Appetite stimulant trial:

Drug Name and Dose: _____ Trial dates: _____

Failure reason: _____

Short Bowel Syndrome

If the request is for Zorbtive [somatropin (rDNA origin) for injection] approval will be granted in patients receiving specialized nutritional support. Zorbtive therapy should be used in conjunction with optimal management of Short Bowel syndrome. PA will be considered for a maximum of 4 weeks.

Provide nutritional support plan: _____

Renewals (in addition to above criteria)

Clinical response to therapy: _____

Reason for use of Non-Preferred drug requiring prior approval: _____

Attach lab results and other documentation as necessary.

Table with 2 columns: Prescriber signature (Must match prescriber listed above.) and Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.