IOWA Health and Human Services

Request for Prior Authorization
GROWTH HORMONES

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

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. The following FDA approved indications for Growth Hormone therapy are considered not medically necessary and requests will be denied; Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). If the criteria for coverage are met, initial requests will be given for 12-months, unless otherwise stated in criteria. Additional prior authorizations will be considered upon documentation of clinical response to therapy and patient continues to meet the criteria for the submitted diagnosis.

Preferred
- ☐ Genotropin
- ☐ Norditropin
- ☐ Nutropin AQ NuSpin

Non- Preferred
- ☐ Humatrope
- ☐ Ngenla
- ☐ Omnitrope
- ☐ Sogroya
- ☐ Tev-Tropin
- ☐ Zorbtive

☐ Skytrofa (after step through preferred short acting growth hormone)

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.

- Childhood Onset
- 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.

Prescriber signature (Must match prescriber listed above.)	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 Health and Human Services, that the member continues to be eligible for Medicaid.