Alaska Medicaid

Human Growth Hormone Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION AND DIAGNOSIS

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

Primary diagnosis: _____

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MEDICAL INFORMATION AND ASSESSMENT

Growth Hormone Treatment

Does the patient have one or more of the following contraindications or exclusions to the use of growth hormone therapy? ☐ Yes ☐ No

- An active malignancy or history of malignancy in the past 12 months
- Active proliferative or severe non-proliferative diabetic retinopathy
- An acute critical illness
- Being used for idiopathic short stature (ISS) or short bowel syndrome
- Some examples of non-approvable diagnoses include Cystic Fibrosis, Constitutional delay of growth and development, or central precocious puberty
- Being used to increase body mass or strength for professional, recreational, or social reasons (e.g., athletes or bodybuilders)
- Being used to reverse the effects of aging (anti-aging)
- Being used to counteract an acute or chronic catabolic illness (excluding HIV/AIDS), which is causing protein wasting changes. For example: burns, sepsis, surgery, trauma, cancer, chronic hemodialysis
- Concurrent use with Increlex® (mecasermin)

Medical Assessment – Please attach growth chart

Current height: _____cm _____%ile Current weight: _____kg _____%ile

Growth Velocity: _____cm _____%ile Date of last exam: _____

Mother's height: _____cm Father's height: _____cm Adopted: ☐ Yes ☐ No

Bone Age: ____y _____m Chronological Age: _____ Epiphyses open: ☐ Yes ☐ No

Growth Hormone Stimulation Testing

Method: _____ Date: _____ Result: _____

Method: _____ Date: _____ Result: _____

Impression: _____

Genetic Test: _____

Other Tests

Test: _____ Date: _____ Result: _____

Test: _____ Date: _____ Result: _____

Test: _____ Date: _____ Result: _____

Genetic Test: _____ Thyroid Function Test: _____

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General Questions – Please complete the following:

1. Has the diagnosis been confirmed by molecular or genetic testing?
   ☐ Yes ☐ No
2. Has the patient completed linear growth or has reached final adult height?
   ☐ Yes ☐ No
3. Does the patient have growth failure as determined by height ≥ 2 standard deviations below the mean for age and gender?
   ☐ Yes ☐ No
4. Does the patient have a growth velocity < 10th percentile of normal for age and gender over the past year?
   ☐ Yes ☐ No
5. Is this for reauthorization? *(if YES, please answer questions 5a and 5b)*
   ☐ Yes ☐ No
   a. Is the patient responding to treatment by clinical assessment?
      ☐ Yes ☐ No
   b. Does the clinical assessment indicate that the patient still needs GH treatment?
      ☐ Yes ☐ No

Specific Questions – Please complete sections only as they related to specific diagnosis of the patient:

Pediatric Growth Failure Due to Chronic Kidney Disease

1. Does the patient have a diagnosis of kidney failure with a GFR ≤ 25 mL/min/1.73m^2 who is awaiting a kidney transplant?
   ☐ Yes ☐ No
2. Does the patient have optimal dietary nutrition (caloric intake)?
   ☐ Yes ☐ No
3. Has the patient received a kidney transplant?
   ☐ Yes ☐ No
4. Has the patient previously received > 3 years of growth hormone treatment?
   ☐ Yes ☐ No
5. Has the patient attained mid-parental target height OR is the patient's height within the 3rd percentile of normal adult height (65 inches for boys and 60 inches for girls)?
   ☐ Yes ☐ No

Last Name: _____ First Name: _____

Growth Failure in Children Born Small for Gestational Age (Includes Intrauterine Growth Restriction or Russell Silver Syndrome)

1. Was the patient born small for gestational age, defined as birth weight or length ≥ 2 standard deviations (SD) below the mean for gestational age?
   ☐ Yes ☐ No
2. Has the patient's growth caught up before 4 years of age, defined by < 2 SD below the mean for age and gender?
   ☐ Yes ☐ No
3. Have other causes for short stature been ruled out?
   ☐ Yes ☐ No

Growth Hormone Deficiency in Children

1. Is the growth velocity of > 2 SD below mean for age and gender for past year?
   ☐ Yes ☐ No
2. Is the Patient Height > 2 SD below mean for age and gender AND growth velocity > 1 SD below mean for age for past year?
   ☐ Yes ☐ No
3. Does the patient have any additional pituitary hormone deficiencies?
   ☐ Yes ☐ No
4. Has the patient had surgery or irradiation of the hypothalamus or pituitary?
   ☐ Yes ☐ No
5. Does the patient have documented subnormal response to growth hormone stimulation testing as defined by ONE of the following?
   - Subnormal response to 2 standard GH stimulation tests; OR
   - Subnormal response to 1 standard GH stimulation test AND a documented low IGF1 for age and gender?

   ☐ Yes ☐ No
6. For **boys**: Is the bone age > 16 years?
   ☐ Yes ☐ No
7. For **girls**: Is the bone age > 14 years?
   ☐ Yes ☐ No
8. Has the patient achieved mid-parental height as defined by > 65 inches (165.1 cm) for boys or 60 inches (152.4 cm) for girls?
   ☐ Yes ☐ No

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Growth Hormone Deficiency in Transition Patient

(Defined as adolescent or young adult who has completed linear growth and growth rate is < 2 cm per year)

1. Has patient completed linear growth AND growth rate of < 2 cm per year?
   ☐ Yes ☐ No
2. Has the GH treatment stopped for a least one month after final height achieved?
   ☐ Yes ☐ No
3. Has the diagnosis been reconfirmed by **ONE** of the following?
   - Patient has > 3 pituitary hormone deficiencies AND IGF1 level< 2.5 percentile off GH therapy.
   - Patient has < 2 pituitary hormone deficiencies AND IGF1 level < 50th percentile for age and gender AND a subnormal response to at least one GH stimulation test.
   - Patient has childhood onset GHD AND multiple pituitary hormone deficiencies AND a low IGF1 level AND a subnormal response to at least one GH stimulation test.

   ☐ Yes ☐ No
4. Has patient had a yearly clinical assessment and evaluation for adverse effects, IgF1 levels and other parameters of GH response?
   ☐ Yes ☐ No

Growth Hormone Deficiency in Adults

1. Has the GH treatment stopped for a least one month?
   ☐ Yes ☐ No
2. Has the diagnosis been reconfirmed by one of the following?
   ☐ Yes ☐ No
3. Patient has > 3 pituitary hormone deficiencies AND IGF1 level < 2.5 percentile when off GH therapy; OR
   - Patient has < 2 pituitary hormone deficiencies AND IGF1 level < 50th percentile for age and gender when off therapy AND a subnormal response to at least one GH stimulation test; OR
   - Patient has history or hypothalamic disease, cranial irradiation, pituitary or hypothalamic surgery, head trauma, or aneurysmal subarachnoid hemorrhage AND multiple pituitary hormone deficiencies AND a low IGF1 level when off therapy AND a subnormal response to at least one GH stimulation test.
   - Patient had documented GHD in childhood AND had subnormal response to 2 standard GH stimulation tests after being off therapy.

   ☐ Yes ☐ No
4. Has patient had a yearly clinical assessment and evaluation for adverse effects, IgF1 levels and other parameters of GH response?
   ☐ Yes ☐ No

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Short Stature Due to Prader-Willi Syndrome

1. Does the patient have a BMI less than 35 kg/m^2?
   ☐ Yes ☐ No
2. Does the patient have any severe respiratory or untreated severe obstructive sleep apnea?
   ☐ Yes ☐ No

☐ Attachments

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____
(required)

Prime Therapeutics Management, LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: (800) 331-4475

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