



Fax Completed form to
1.877.386.4695
Provider Help Desk
1.866.399.0928

**Request for Prior Authorization
GROWTH HORMONES**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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.