MARYLAND MEDICAID PHARMACY PROGRAM
PH 1-800-932-3918
FAX 1-866-440-9345

Maryland
DEPARTMENT OF HEALTH

GROWTH HORMONE (GH) PRIOR-AUTHORIZATION REQUEST
INITIATION AND CONTINUATION OF GH THERAPY- APPROVAL OF THE NON-PREFERRED DRUG

Incomplete forms will be returned.

Section I- Patient Information

Name:_____ MA ID#:_____ DOB:_____ Phone:_____ Other insurance:_____

Section II- Prescriber Statement of Medical Necessity/Drug/Clinical Information

Prescriber:_____ Ph.:_____ Fax:_____ Address:_____
Endocrinologist or nephrologist Yes ☐ No ☐ Estimated length of GH therapy:_____
I certify that this treatment is medically necessary and meets the guidelines of the Maryland Medicaid Program. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

Prescriber's Signature:_____ Date: _____ License #: _____

1. Initial request ☐ Renewal ☐ Drug/Dosage frequency:_____
   The Preferred drugs are Norditropin, Nutropin, Nutropin AQ, and Genotropin. Complete Section III if request is for a non-preferred drug.
2. Patient's weight: _____lbs or_____kgs Date patient last seen:_____ Primary diagnosis:_____ (Do not use ICD-9)
3. Confirmed by a board certified endocrinologist or nephrologist? Yes ☐ No ☐
4. Diagnostic tests: GH deficiency (GHD) confirmed with provocative testing and IGF-1 level for both children and adults with GHD:

   ☐ Adult with childhood onset GHD or with additional pituitary hormone deficits- 1 stimulating test required

   ☐ Adult and children with suspected GHD with no other pituitary hormone deficits- at least 2 stimulating tests required

   Test 1: type_____ Results: _____mg/ml- Normal range: _____ Test Date: _____

   Test 2: type_____ Results: _____mg/ml- Normal range: _____ Test Date: _____

   As provocative testing, ITT is required unless contraindicated. If contraindicated (seizures, CAD, abnormal EKG with history of IHD or CVD, and not advised for those>age 60), documentation must be provided and an alternative test result (arginine, glucagon, GH releasing hormone, L-dopa and combination of these agents, excluding clonidine) may be substituted. For patients with Chronic Renal Insufficiency (CRI) on dialysis, only an IGF-1 level is required.
   Insulin-Like Growth Factor-1 (IGF-1) level (required annually): _____mg/ml Date: _____
   Is there a contraindication to Insulin Tolerance Test (ITT)? Yes ☐ No ☐ If yes, state reason:
   _____

   If request is for adult GH therapy, skip items 5&6 below.
   If request is for a child, is the patient's height less than the 3rd percentile, or if **2.00** standard deviation (SD) or more below mean height for chronological age?
   Yes ☐ No ☐ Height: ____ft _____in Percentile _____ Attach copy of growth chart.
5. Bone age: _____ ; Chronological age:_____ Date of most recent radiology report:_____
   Is bone age < chronological age <=- 16 yrs (boys);<= 14 yrs (girls)? Yes ☐ No ☐ Has bone fused? Yes ☐ No ☐
6. For adults requiring GH therapy, provide results of bone density test, if done- T score _____on DEXA testing or _____ SD by WHO
7. Has the patient been screened for intracranial malignancy/tumor? *(If no, request will be denied)* Yes ☐ No ☐
   If a h/o of malignancy exists, has it been free of recurrence for at least the past 6 months? Yes ☐ No ☐ No malignancy☐
8. Does the patient have any of the following contraindications? If any of these apply, request will be denied.

   ☐ Pregnancy ☐ Proliferative/preproliferative diabetic retinopathy; ☐ Pseudotumor cerebri or benign intracranial HTS___

   ☐ Status/post renal transplantation; ☐ Untreated chronic disease causing growth failure (i.e. hypothyroidism, liver disease, etc.) Explain:

   _____
9. Is patient on: Corticotropin? Yes ☐ No ☐ Systemic glucocorticoids? Yes ☐ No☐ Antitumor chemotherapy? Yes ☐ No ☐
10. Results of thyroid function tests (required every 6 months):

    _____
11. List any other pertinent lab tests done with results:_____

Section III- Prior-Auth of Non-Preferred Drugs

If a preferred drug is selected, skip this Section. The non-preferred drugs are: **Omnitrope, Saizen, Tev-Tropin, Serostim, Humatrope, and Zorbtive.** These products are synthetic somatropin of recombinant DNA origin, considered therapeutically equivalent to endogenous growth hormones and therefore interchangeable based on their international unit dosing equivalency. They vary in dosage strengths and forms, added preservatives, length of stability after mixing, and FDA-approved indications. Prescribers should only use a non-preferred drug when absolutely necessary. Patients who have been receiving a preferred drug that has become non-preferred do **not** need to be switched to an agent on the preferred drug list. If prescribers must use a non-preferred drug for a patient's initial growth hormone therapy, please provide valid reasons for selecting the non-preferred drug:

_____

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Section IV- Children GH Therapy Evaluation- (If adult, skip this section and complete Section V).

Diagnoses: Patient must have one of the following primary indications listed below. Please check applicable diagnosis:

- ☐ Documented growth hormone deficiency
- ☐ Turner Syndrome- Is diagnosis confirmed by karyotyping? Yes ☐ No☐
- ☐ Prader Willi Syndrome- Is diagnosis confirmed by appropriate chromosomal testing? Yes ☐ No☐
  Submit documentation of chromosomal abnormality. No need for provocative testing. Reassess need for continued long-term therapy in obese patients and those with severe respiratory&vascular complications.
- ☐ Growth deficiency due to chronic/irreversible renal insufficiency. Is patient on dialysis? Yes ☐ No☐
  If no, request will be denied.
- ☐ If none of the above, explain:

_____

Continuation of therapy: Provide the following:

- ☐ Date of last office visit: _____ Date when GH therapy was initiated: _____
- ☐ Growth chart (Attach)- Height <25th percentile of normal height for gender? Yes ☐ No☐
- ☐ If goal of 25th percentile of normal height has been achieved, please reassess and provide rationale for patient's continued GH therapy:

_____

- ☐ Epiphyses open? Yes ☐ No☐ Anticipated length of therapy:_____
- ☐ Height velocity >= 2.5cm/yr over previous untreated rate Yes ☐ No☐
  Height velocity measured over at least 6 months with at least 2 measurements: _____ cm per _____ months.
- ☐ Bone age per radiological report: _____ Date of test: _____ Chronological age: _____
- ☐ Normal thyroid function test? Yes ☐ No☐ IGF-1 level: _____ ng/ml Test date: _____
- ☐ Based on results of recommended lab tests, thyroid function tests and IGF-1 levels (both initially and at least annually thereafter), is continuation of GH therapy justified? Yes ☐ No☐ IGF-1 level: _____ ng/ml
- ☐ Comment on GH therapy efficacy, adverse effects, any compliance issues:

_____

Section V - Adult Growth Hormone Therapy Evaluation

Diagnoses: Patient must have one of the following primary indications. Check applicable diagnosis:

- ☐ Adult with childhood onset of growth hormone deficiency
- ☐ Adult onset of growth hormone deficiency with no other deficiencies
- ☐ Adult onset of growth hormone deficiency with other pituitary hormone deficiencies
  If none of the above, explain:

_____

Continuation of therapy: Provide the following:

1. IGF-1 level (within the past 12 months): _____ ng/ml Date of test: _____
2. Based on annual evaluation of fasting lipid profile, BUN, fasting glucose, electrolyte levels, bone density testing (recommended after the first year, then every 3 years thereafter), is continuation of GH therapy justified? Yes ☐ No☐ Anticipated length of therapy: _____
3. Comment on GH therapy efficacy, adverse effects, any compliance issues:

_____

INTERNAL USE

Clinical PA: ☐ Approved: _____ / _____ Approval is for 6 months from: _____ to _____
(Medical necessity for growth hormone therapy must be renewed every 6 months)
☐ **Rejected:** _____ / _____ **Patient does not meet criteria.**

PDL PA (Use of Non-Preferred Drug): ☐ **Approved** ☐ **Rejected** - Invalid reason