Growth Hormone Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (833) 325-0105

Date (mm/dd/yyyy): _____

Patient information

Name: _____ DOB: _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber information

Name: _____ Specialty: ❑ Endocrinologist ❑ Nephrologist. NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

Prescription information

❑ Initial request ❑ Renewal request

Medication: _____ Strength: _____ Quantity: _____

Direction for use: _____

Is it a Preferred medication: ❑ Yes ❑ No

Please refer to the MDH Preferred Drug List (PDL)

Non-preferred medications can be requested when preferred medications are not appropriate for the patient. Justification must be provided: _____

Diagnostic tests

- *Growth hormone deficiency (GHD) must be confirmed with provocative testing and insulin like growth factor -1 (IGF-1) level in both children and adults.*
- *One stimulating test is required for adult with childhood onset GHD with additional pituitary hormone deficiency*
- *At least two stimulating tests are required for Adults and children with suspected GHD with no other pituitary hormone deficiency.*

Test 1. Type: _____ Result: _____ mg/ml Normal range: _____ Date (mm/dd/yyyy): _____

Test 2. Type: _____ Result: _____ mg/ml Normal range: _____ Date (mm/dd/yyyy): _____

Insulin tolerance test (ITT). Result: _____ Date (mm/dd/yyyy): _____

ITT is a required provocative test unless contraindicated for (select that applies): ❑ Seizures ❑ Coronary artery disease ❑ Abnormal EKG with history of ischemic heart disease or cardiovascular disease ❑ age >60. In that case, an alternate test result may be given.

Alternate test (when ITT is contraindicated): _____ Result: _____ Date (mm/dd/yyyy): _____

The level of arginine, glucagon, GH releasing hormone, L-dopa and combination of these agents, excluding clonidine can be an alternative test.

Insulin-like growth factor-1 (IGF-1) level: _____ mg/ml Date (mm/dd/yyyy): _____

IGF-1 level is required annually for patients who have chronic renal insufficiency and on dialysis.
Submit test results for review

Pediatric patients

Diagnosis

❑ Growth failure due to GHD ❑ Noonan syndrome ❑ Turner Syndrome ❑ Prader Willi Syndrome ❑ Small for Gestational age ❑ Growth deficiency due to chronic/irreversible renal insufficiency up to the renal transplant ❑ Idiopathic Short Stature ❑ Other: _____

Chronological age: _____ Bone age: _____ Height: _____ ft _____inch Date (mm/dd/yyyy): _____

❑ Yes ❑ No Height less than 3rd percentile or ≥2.00 standard deviation (SD) below mean height for chronological age

❑ Yes ❑ No Bone age less than chronological age (≤ 16 years for boys and ≤ 14 years for girls)

❑ Yes ❑ No Bone fused

Attach copy of growth chart

For continuation of therapy

Date of growth hormone therapy initiated: _____

❑ Growth chart <25% of normal height for gender

If the goal of 25% of normal height has been achieved, please reassess and provide rationale for the continuation of GH therapy _____

Epiphyses open? Yes ❑ No❑ If yes, anticipated length of therapy: _____

Height velocity: _____ cm per _____ month

Height velocity should be measured over at least six months with at least two measurements

❑ Yes ❑ No Based on IGF and thyroid function test results, continuation of GH therapy justified

Adult patients

Diagnosis

❑ Adult with childhood onset GHD ❑ Adult with adult-onset GHD ❑ Other: _____

T-score on DEXA (if done): _____ SD by WHO: _____

Thyroid function test result (required): _____ Date (mm/dd/yyyy): _____

Other pertinent tests done: _____

For continuation of therapy

Yes ❑ No ❑ Continuation of GH therapy is justified based on annual evaluation of IGF-1 level, fasting lipid profile, BUN, fasting glucose, electrolyte levels, bone density testing (recommended after the first year, then every 3 years thereafter). Anticipated length of therapy: _____

I attest that

❑ All possible contraindications reviewed and evaluated as per package insert.

❑ Patient's lab/test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial and that the benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature _____ Date (mm/dd/yyyy) _____