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3404 Cooney Drive, Helena, MT 59602
Phone 406.443.6002 • Toll Free Phone 1.800.395.7961
Fax 406.513.1928 • Toll Free Fax 1.800.294.1350

Montana Medicaid Prior Authorization for use of Growth Hormones

(Preferred Growth Hormones: Norditropin® and Nutropin AQ®)

Patient Information		**Prescriber Information**	Date:
Name:		Name:	
DOB:	Gender:	Specialty:	
Medicaid ID #:		Phone:	Fax:
Requested Drug Name/Dosage Form/Strength:		Office Contact for Request:	

Please complete information below and <u>ATTACH ALL SUPPORTING DOCUMENTATION</u> for applicable situation, <u>Initiation</u> or <u>Continuation</u> of therapy (updates required annually):

☐ INITIATION OF THERAPY Please indicate diagnosis:

(Note: Small for Gestational Age/Idiopathic Short Stature in absence of GH deficiency are excluded from coverage):

☐Growth hormone deficiency (GHD)-pediatric ☐Prader-Willi syndrome ☐Noonan syndrome
☐Growth hormone deficiency (GHD)-adult ☐Turner syndrome ☐Short bowel syndrome
☐Chronic renal insufficiency (with estimated GFR < 75 ml/min–Provide eGFR: _____ml/min) ☐HIV/AIDS wasting or cachexia

1. Has a brain MRI been performed to exclude the possibility of an intracranial lesion/tumor? ☐Yes ☐No ☐N/A
   If no MRI performed, provide rationale: _____
2. Is the patient's height more than 2SD below mean height for chronological age? ☐Yes ☐No ☐ N/A-adult
3. Is the patient's growth velocity < 5 cm/year? ☐Yes ☐No ☐N/A-adult Growth Velocity: _____ Date: _____
4. Is bone age <14-15 years (female); <15-16 years (male)? ☐Yes ☐No ☐N/A-adult Epiphyses are: ☐Open ☐Closed ☐ N/A-adult
5. **<u>IF</u> GHD (Pediatric):** <u>TWO</u> provocative GH stimulation tests (must be <10 ng/ml) required unless known pathology of CNS, h/o irradition, other pituitary defects, or other genetic condition associated with GHD (only <u>ONE</u> stimulation test required):
   Test 1: type_____ Peak GH Value: _____ng/ml Date: _____
   Test 2: type_____ Peak GH Value: _____ng/ml Date: _____
   If only one test submitted, provide rationale:_____
6. **<u>IF</u> GHD (Adult):**
   ☐ Adult with history of pediatric GHD; Or adult onset with hypothalamic or pituitary disease and at least <u>one</u> other pituitary hormone deficiency *<u>requiring replacement</u>*: Provide IGF-1 level and <u>one</u> GH stimulation test result:
   IGF-1 level: ____ ng/ml *Normal IGF-1 range: _____ng/ml* GH Stimulation Test type_____Peak GH Value: _____ng/ml
   ☐ Adult onset with hypothalamic or pituitary disease <u>and</u> documented <u>panhypopituitarism</u> *<u>requiring replacement</u>*? ☐Yes ☐No
   IGF-1 level required:_____ng/ml *Normal IGF-1 range: _____ng/ml*
   - Indicate current hormone replacement therapies:

     _____

4. Provide additional pertinent information if necessary (i.e. reason for request of non-preferred drug, etc.):

_____
_____

☐ CONTINUATION OF THERAPY UPDATE (Information below required for pediatric GH deficiency, chronic renal insufficiency, Prader-Willi/Turner/Noonan syndrome. Update only required for other diagnoses).

1. **Bone age must be <14-15 years (female); <15-16 years (male)**
   Bone age per radiological report: _____ Date of last bone age test: _____
2. Epiphyses are: ☐Open ☐Closed

Please complete form, including required attachments and fax to:
Medicaid Drug Prior Authorization Unit
1-800-294-1350