

### Montana Medicaid Prior Authorization for use of Growth Hormones

(Preferred Growth Hormones: Norditropin<sup>®</sup> and Nutropin AQ<sup>®</sup>)

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 ATTACH ALL SUPPORTING DOCUMENTATION for applicable situation, Initiation or Continuation of therapy (updates required annually):**

**INITIATION OF THERAPY** Please indicate diagnosis:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Growth hormone deficiency (GHD)-pediatric   | <input type="checkbox"/> Prader-Willi syndrome        | <input type="checkbox"/> Noonan syndrome      |
| <input type="checkbox"/> Growth hormone deficiency (GHD)-adult   | <input type="checkbox"/> Turner syndrome              | <input type="checkbox"/> Short bowel syndrome |
| <input type="checkbox"/> Chronic renal insufficiency (with estimated GFR < 75 ml/min—Provide eGFR: _____ ml/min) | <input type="checkbox"/> HIV/AIDS wasting or cachexia |   |
| <input type="checkbox"/> Other: _____  |   |   |

(Note: Diagnoses of Small for Gestational Age (SGA)/Idiopathic Short Stature (ISS) require proof of medical necessity with supporting documentation detailing how the condition is adversely affecting the patients's physical health).

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. **IF GHD (Pediatric): TWO** provocative GH stimulation tests (must be <10 ng/ml) required unless known pathology of CNS, h/o irradiation, other pituitary defects, or other genetic condition associated with GHD (only **ONE** 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. **IF GHD (Adult):**  
 Adult with history of pediatric GHD; Or adult onset with hypothalamic or pituitary disease and at least **one** other pituitary hormone deficiency **requiring replacement**: Provide IGF-1 level and **one** 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 **and** documented **panhypopituitarism requiring replacement?**  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**