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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 ATTACH ALL SUPPORTING DOCUMENTATION for applicable situation, Initiation or Continuation 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. **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