



New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Growth Hormone Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Is the prescriber an endocrinologist or nephrologist, or has one been consulted on this case? ☐ Yes ☐ No
2. Has an MRI of the brain been performed? ☐ Yes ☐ No
3. What is the patient's age? _____ What is the patient's height? _____
4. Is patient a newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism? ☐ Yes ☐ No

(Form continued on next page.)



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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (*Continued*)

5. What is the diagnosis/condition being treated with this medication? (Check all that apply.)

- | | | |
|----------------------------------------------------------------|------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Growth hormone deficiency (pediatric) | <input type="checkbox"/> Growth hormone deficiency (adult onset) | <input type="checkbox"/> Prader-Willi Syndrome |
| <input type="checkbox"/> Turner Syndrome | <input type="checkbox"/> Renal Insufficiency | <input type="checkbox"/> Chronic Renal Insufficiency |
| <input type="checkbox"/> Noonan Syndrome | <input type="checkbox"/> HIV wasting or cachexia | <input type="checkbox"/> Small for Gestational Age |
| <input type="checkbox"/> Short Stature Homeobox gene | | <input type="checkbox"/> Idiopathic Short Stature |

LAB/TEST RESULTS (Please provide all lab/test results that apply to the condition being treated.)

6. Are the epiphyses open or closed? _____
7. What are the results of bone age studies? _____
8. Is the patient's height more than 2 SD below average for population mean height for age and sex? ☐ Yes ☐ No
9. Is the patient's height velocity measured over one year to be 1 SD below the mean for chronological age? ☐ Yes ☐ No
10. For children over two years of age, has there been a decrease in height SD of more than 0.5 over one year? ☐ Yes ☐ No
11. What is the patient's growth hormone response to a provocative stimulation test? (Two are required: insulin, levodopa, L-Arginine, clonidine, or glucagon) _____ ng/mL
12. In adult onset growth hormone deficiency, have the following hormonal deficiencies been ruled out? (Check all that apply.)
- | | | |
|----------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Cortisol | <input type="checkbox"/> Sex Steroids |
|----------------------------------|-----------------------------------|---------------------------------------|

(Form continued on next page.)



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SECTION III: CLINICAL HISTORY (*Continued*)

MISCELLANEOUS REQUIRED INFO (Please provide if applicable.)

13. If being prescribed for AIDS wasting or cachexia, has the patient had documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace and Marinol)? ☐ Yes ☐ No

14. (Ngenla®, Skytrofa®, and Sogroya® only): Has the patient had a trial of a short-acting somatropin product? ☐ Yes ☐ No

If yes, please list treatment failures and provide dates:

15. If this is a renewal, has patient had a positive response to therapy? ☐ Yes ☐ No

Please provide information to support a positive response to therapy (e.g., improvements in height, weight, body composition, increased growth velocity, response on growth curve chart).
Please provide quantitative improvements.

16. Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____

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MagellanRx
MANAGEMENTSM