Reset Form

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

Patient's Name

Medicaid Number

Date of Birth (MM/DD/YYYY) / /

Gender ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: CLINICAL HISTORY

1. **Is the prescriber an endocrinologist, 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
5. **What is the diagnosis/condition being treated with this medication?** (or check all that apply)

☐ Growth hormone deficiency (pediatric) ☐ Growth hormone deficiency (adult onset) ☐ Prader-Willi Syndrome
☐ Turner Syndrome ☐ Renal Insufficiency ☐ Chronic Renal Insufficiency
☐ Short Bowel Syndrome ☐ HIV wasting or cachexia ☐ Small for Gestational Age
☐ Noonan Syndrome ☐ Short Stature Homeobox gene ☐ Idiopathic Short Stature

LAB/TEST RESULTS (PLEASE PROVIDE ALL LAB/TEST RESULTS THAT APPLY TO THE CONDITION BEING TREATED.)

1. **Are the epiphyses open or closed?** _____
2. **What are the results of bone age studies?** _____
3. **Is patient's height more that 2 SD below average for population mean height for age and sex?** ☐ Yes ☐ No
4. **Is the patient's height velocity measured over one year to be 1 SD below the mean for chronological age?** ☐ Yes ☐ No
5. **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
6. **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
7. **In adult onset growth hormone deficiency, have the following hormonal deficiencies been ruled out?** (or check all that apply)
   ☐ Thyroid ☐ Cortisol ☐ Sex Steroids

MISCELLANEOUS REQUIRED INFORMATION (PLEASE PROVIDE IF APPLICABLE)

1. **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
2. **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 (i.e., improvements in height, weight, body composition, increased growth velocity, response on growth curve chart). Please provide quantitative improvements.

   _____

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

   _____

SECTION III: PRESCRIBER INFORMATION

Name

NPI Number

Prescriber Phone Number -

Prescriber Fax Number -

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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