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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: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

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

☐ Thyroid ☐ Cortisol ☐ Sex Steroids

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MagellanRx MANAGEMENT℠

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

Growth Hormone Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY (*CONTINUED*)

MISCELLANEOUS REQUIRED INFO (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.

   _____

3. 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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