

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Gender: Male Female

Is Member Over 18 Years of Age? Yes No

PRESCRIBER INFORMATION

Last Name:

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First Name:

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NPI Number:

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Phone Number:

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Fax Number:

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Is the Drug Prescribed by or in Consultation with a Specialty?

Endocrinologist Nephrologist

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Quantity per Day: _____

All Growth Hormone medications require the submission of a Clinical Service Authorization

Preferred Medications:

Genotropin[®] Norditropin FlexPro[®]

Non-Preferred Medications:

Humatrope[®] cartridge/vial Nutropin AQ[®] NuSpin[®] Nutropin AQ[®] cartridge/vial
 Omnitrope[®] cartridge/vial Saizen[®] cartridge/vial Serostim[®] vial
 Zomacton[®] vial Zorbitive[®] vial

If requesting a non-preferred agent, please document why a preferred agent cannot be used:

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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CRITERIA

1. What is the diagnosis?

- | | |
|---|---|
| <input type="checkbox"/> Idiopathic short stature (ISS) | <input type="checkbox"/> Pediatric growth hormone (GH) deficiency |
| <input type="checkbox"/> Noonan syndrome (NS) | <input type="checkbox"/> Familial short stature |
| <input type="checkbox"/> SHOX deficiency (SHOXD) | <input type="checkbox"/> Small for gestational age (SGA) |
| <input type="checkbox"/> Adult GH deficiency | <input type="checkbox"/> Turner syndrome (TS) |
| <input type="checkbox"/> Prader Willi syndrome (PWS) | <input type="checkbox"/> Short bowel syndrome (SBS), skip to diagnosis section |
| <input type="checkbox"/> Chronic renal insufficiency | <input type="checkbox"/> Pediatric chronic kidney disease, skip to diagnosis section |
| <input type="checkbox"/> Other: _____ | |

2. Is this request for a new start, restart (re-initiation) or continuation of Growth Hormone (GH) therapy?

- New start, **skip to diagnosis section** Restart, **skip to diagnosis section** Continuation

3. Is the member's growth velocity at least 2 cm per year while on GH therapy?

- Yes No

Action Required: *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*

4. Are the growth plates open?

- Yes No

5. What is the member's current height? Age: Years _____ Months _____ Height: _____ inches

Action Required: *Please attach documentation from the medical record of current height.*

DIAGNOSIS AND MEDICAL INFORMATION

Complete the Following Section(s) Based on the Member's Diagnosis. Complete All That Apply:

Section A: All Pediatric Indications

6. What is the member's pretreatment height and age?

Age: Years _____ Months _____ Height: _____ inches

Action Required: *Please attach documentation from the medical record showing pretreatment height and age at measurement.*

7. Which of the following criteria does the member's pretreatment height meet?

- Greater than or equal to 2.25 standard deviations (SD) below the mean for age and gender
 Greater than or equal to 2 standard deviations (SD) below the mean for age and gender

8. What is the member's pretreatment growth velocity?

- Greater than 1 standard deviation (SD) below the mean for age and gender
 1 SD below the mean for age and gender

Action Required: *Please attach documentation from the medical record showing either.*

- At least 2 heights measured by an endocrinologist at least 6 months apart (data for at least 1 year)
 At least 4 heights measured by a primary care physician at least 6 months apart (data for at least 2 years)

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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Section B: Pediatric GH Deficiency

9. Did the member have a GH response of less than 10 ng/mL (or otherwise abnormal as determined by the lab) of at least 2 GH stimulation tests LFTs?

Yes No

Action Required: *If YES, please attach documentation of stimulation test results.*

10. Did member have a GH response of less than 15 ng/mL on at least 1 GH stimulation test?

Yes No

Action Required: *Please attach documentation of GH stimulation test result. If YES, indicate results.*

11. Does the member have a defined CNS pathology, history of cranial irradiation or genetic condition associated GH deficiency?

Yes No

12. Does the member have both IGF-1 and IGFBP-3 levels below normal for age and gender?

Yes No

Action Required: *If YES, please attach documentation from the medical record showing IGF-1 and IGFBP-3 levels below normal.*

13. Does the member have 2 or more documented pituitary hormone deficiencies other than GH?

Yes No

14. Did the member have an abnormally low GH level in association with neonatal hypoglycemia?

Yes No

Action Required: *If YES, please attach documentation of GH level.*

Section C: Pediatric Chronic Kidney Disease/Chronic Renal Insufficiencies

15. Does the member have any of the following? Indicate any/all the apply:

<input type="checkbox"/> Creatinine clearance of 75 mL/min/1.73 m ² or less	<input type="checkbox"/> Dialysis dependency
<input type="checkbox"/> Serum creatinine greater than 3.0 g/dL	<input type="checkbox"/> None of the above

Section D: Pediatric Chronic Kidney Disease

16. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?

New start, *no further questions* Restart Continuation

17. Was GH therapy previously approved for this member?

Yes No

18. What is the member's current height in inches? _____

Action Required: *Please attach documentation from the medical record of current height. If Restart, no further questions.*

19. Is the member's growth velocity at least 2 cm per year while on GH therapy?

Yes No

Action Required: *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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Section E: Adult GH Deficiency

- 20. Does the member have irreversible hypothalamic/pituitary structural lesions or ablation?
 Yes No **If YES, no further questions.**
- 21. Does the member have a defect in GH synthesis?
 Yes No **If YES, no further questions.**
- 22. Did the member have GH deficiency diagnosed during childhood?
 Yes No
- 23. Does the member have 3 or more pituitary hormone deficiencies?
 Yes No
- 24. Was the member retested for GH deficiency after an at least 1-month break in GH therapy?
 Yes No
- 25. Which of the following pharmacologic agents was used in a GH stimulation test to measure peak GH levels?
 Insulin Clonidine Levodopa Glucagon Arginine
 GH stimulation test not performed Other: _____

Action Required: Please attach documentation showing the results of GH stimulation test.

- 26. Indicate the peak GH level: _____ ng/mL
- 27. Is the pretreatment IGF-1 level below the laboratory's range of normal?
 Yes No

Action Required: Please attach documentation from the medical record showing the member's pretreatment IGF-1 level.

Section F: Short Bowel Syndrome

- 28. Is the member receiving specialized nutritional support?
 Yes No
- 29. Will GH be used in conjunction with optimal management of short bowel syndrome?
 Yes No
- 30. How many months of GH therapy has the member received? _____ months Not Applicable/New Start

Prescriber Signature (Required)

Date

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-922-3986**, phoned to **1-800-424-4524 (TTY 711)** or mailed to:

Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.

11013 West Broad Street, Glen Allen, VA 23060

Magellan Complete Care of Virginia CCC Plus website: <https://mccofva.com/>

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