

**State of Alaska Division of Medical Assistance  
Human Growth Hormone Prior Authorization Form  
Revision 1, 4/3/03**

Patient Name: \_\_\_\_\_ Medicaid ID: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
 Patient DOB: \_\_\_\_\_ Sex \_\_\_\_\_ Diagnosis \_\_\_\_\_  
 Printed Physician Name \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

HGH must be prescribed by a Pediatric Endocrinologist.

Requested product - √	Drug Name	Strength - Note 5, 10 mg or Cartridge Strength	Daily dosage & frequency	Quantity of vials, cartridges requested	Start date
	Genotropin				
	Humatrope				
	Norditropin				
	Nutropin AQ, Depot				
	Protropin				
	Saizen				

Medical Assessment, please attach growth chart:

Current height \_\_\_\_\_ cm \_\_\_\_\_ % ile. Growth Velocity: \_\_\_\_\_ cm/yr. \_\_\_\_\_ % ile. Last Exam \_\_\_\_\_ date  
 Current Weight: \_\_\_\_\_ kg \_\_\_\_\_ % ile. Mother's Height: \_\_\_\_\_ cm Father's Height: \_\_\_\_\_ cm Adopted \_\_\_\_\_  
 Bone Age: \_\_\_\_\_ y \_\_\_\_\_ mo Chronologic Age: \_\_\_\_\_ Epiphyses Open: Y/N

Growth Hormone Stimulation Testing:

Method: \_\_\_\_\_ Date \_\_\_\_\_ Level: \_\_\_\_\_  
 Method: \_\_\_\_\_ Date \_\_\_\_\_ Level: \_\_\_\_\_  
 Impression: \_\_\_\_\_  
 Genetic test \_\_\_\_\_

Other Tests:

Test: \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_  
 Test: \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_  
 Test: \_\_\_\_\_ Date \_\_\_\_\_ Result \_\_\_\_\_  
 Thyroid Function Test: \_\_\_\_\_

Documentation of Medical Necessity for product coverage used for growth failure and labeled indications:

Growth Hormone Deficiency - Coverage of GH for children and adolescents who meet 1a, 1b, and 1c below:

- 1a. Patient has growth failure < 3 percentile or > 2 SD below the 50<sup>th</sup> percentile on a growth chart showing between 3<sup>rd</sup> and 97<sup>th</sup> percentile; **AND**
- 1b. Growth retardation: Patient's height velocity < 10<sup>th</sup> percentile of normal for age & sex and is tracked over one year; **AND**
- 1c. Lack of response to standard GH stimulation tests: < 10 ng; for insulin / L-Dopa / arginine / clonidine / glucagon / propranolol.

Chronic Renal Insufficiency - Coverage of GH for children and adolescents prior to transplantation who meet 2a, 2b, and 2c below:

- 2a. Patient has growth failure < 3 percentile or > 2 SD below the 50<sup>th</sup> percentile on a growth chart showing between 3<sup>rd</sup> and 97<sup>th</sup> percentile for age and sex; **AND**
- 2b. Growth retardation: Patient's height velocity < 10<sup>th</sup> percentile of normal for age & sex and is tracked over one year; **AND**
- 2c. Clinical history & lab measurements consistent with kidney failure.

State of Alaska Division of Medical Assistance  
 Human Growth Hormone Prior Authorization Form  
 Revision 1, 4/3/03

□ Turner Syndrome – Coverage of GH for children with growth retardation who meet 3a, 3b, and 3c below:

- 3a. Patient has growth failure < 3 percentile or > 2 SD below the 50<sup>th</sup> percentile on a growth chart showing between 3<sup>rd</sup> and 97<sup>th</sup> percentile for age and sex; AND
- 3b. Growth retardation: Patient's height velocity < 10<sup>th</sup> percentile of normal for age & sex and is tracked over one year; AND
- 3c. Diagnosis of Turners Syndrome is confirmed by appropriate genetic testing.

□ Prader-Willi Syndrome - Coverage of GH for children with Prader-Willi Syndrome and growth retardation requires that patients meet 2a, 2b, and 2c below:

- 4a. Patient has growth failure < 3 percentile or > 2 SD below the 50<sup>th</sup> percentile on a growth chart showing between 3<sup>rd</sup> and 97<sup>th</sup> percentile for age and sex; AND
- 4b. Growth retardation: Patient's height velocity < 10<sup>th</sup> percentile of normal for age & sex and is tracked over one year; AND
- 4c. Diagnosis of Prader-Willi Syndrome is confirmed by appropriate genetic testing.

□ Orphan Drug Indication:

Russell-Silver or Interuterine growth retardation – Coverage of GH for children with growth retardation who meet all the following: The diagnosis of this requires review of the Medical Consultants, Qualis.

□ Re-authorization: HGH will be re-authorized every six months the first year, then yearly thereafter. Re-authorization will be denied if 5a, or 5b, or 5c is true:

- 5a. Growth velocity is less than 2 cm/yr over one year of therapy; or
- 5b. Growth epiphyses are fusing (Bone age is greater than or equal to 14 years in girls or 16 in boys); or
- 5c. Height is within the 3<sup>rd</sup> percentile of normal adult height (65 inches in boys, 60 inches in girls).

Physician's Signature: \_\_\_\_\_

<b>MAGELLAN USE ONLY:</b>	<b>[ ] APPROVED [ ] CHANGED [ ] DENIED</b>
DATE _____	LENGTH OF AUTHORIZATION _____
MAP PHARMACIST / TECHNICIAN _____	COMMENTS _____
NDC NUMBER _____	

**SUBMIT REQUESTS TO:** MAGELLAN MAP DESK FAX: (888) 603-7696 TELEPHONE: (800) 331-4475

**State of Alaska Division of Medical Assistance  
Human Growth Hormone Prior Authorization Form  
Revision 1, 4/3/03**

---

Drug Name & Labeled indications for Pediatric Patients as of 11/19/02; uses other than those below require review by our Medical Consultants

Genotropin ®- is indicated for Long-term treatment of pediatric patients who have growth failure due to an inadequate secretion of endogenous growth hormone (GH). Genotropin Long-term treatment of pediatric patients who have growth failure due to Prader-Willi syndrome (PWS). The diagnosis of PWS should be confirmed by appropriate genetic testing.

Humatrope ®- Pediatric patients with growth failure due to inadequate secretion of normal endogenous growth hormone or treatment of short stature for those with Turner's Syndrome whose epiphyses have not closed.

Norditropin ®- Growth failure due to GHI. Growth failure in girls due to gonadal dysgenesis (Turner syndrome). Growth retardation in prepubertal children due to Chronic Renal Disease.

Nutropin ® - is also indicated for the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation. Nutropin therapy should be used in conjunction with optimal management of chronic renal insufficiency; Nutropin®] is also indicated for the long-term treatment of short stature associated with Turner syndrome.

Nutropin AQ® is indicated for the long-term treatment of growth failure due to a lack of adequate endogenous GH secretion. Nutropin AQ® is also indicated for the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation. Nutropin AQ therapy should be used in conjunction with optimal management of chronic renal insufficiency. Nutropin AQ® is also indicated for the long-term treatment of short stature associated with Turner syndrome.

Nutropin Depot® is indicated for treatment of growth failure due to a lack of adequate endogenous GH secretion

Protropin ®- is indicated only for the long-term treatment of children who have growth failure due to a lack of adequate endogenous growth hormone secretion.

Saizen ® - is indicated for the long-term treatment of children with growth failure due to inadequate secretion of endogenous growth hormone.

---