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: _______

GHG must be prescribed by a Pediatric Endocrinologist.

<table>
<thead>
<tr>
<th>Requested product</th>
<th>Drug Name</th>
<th>Strength – Note 5, 10 mg or Cartridge Strength</th>
<th>Daily dosage &amp; frequency</th>
<th>Quantity of vials, cartridges requested</th>
<th>Start date</th>
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<td>Genotropin</td>
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<td>Humatrope</td>
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<td>Norditropin</td>
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<td>Nutropin AQ, Depot</td>
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<td>Protropin</td>
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<td>Saizen</td>
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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: Other Tests:
Method: _______ Date _______ Level: _______ Test: _______ Date _______ Result _______
Method: _______ Date _______ Level: _______ Test: _______ Date _______ Result _______
Impression: _______ Test: _______ Date _______ Result _______
Genetic test _______ 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 50th percentile on a growth chart showing between 3rd and 97th percentile; AND
  1b. Growth retardation: Patient's height velocity < 10th 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 50th percentile on a growth chart showing between 3rd and 97th percentile for age and sex; AND
  2b. Growth retardation: Patient's height velocity < 10th percentile of normal for age & sex and is tracked over one year; AND
  2c. Clinical history & lab measurements consistent with kidney failure.
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 50th percentile on a growth chart showing between 3rd and 97th percentile for age and sex; AND
3b. Growth retardation: Patient’s height velocity < 10th percentile of normal for age & sex and is tracked over one year; AND
3c. Diagnosis of Turner 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 50th percentile on a growth chart showing between 3rd and 97th percentile for age and sex; AND
4b. Growth retardation: Patient’s height velocity < 10th 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 3rd percentile of normal adult height (65 inches in boys, 60 inches in girls).

Physician’s Signature:

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<th>MAGELLAN USE ONLY:</th>
<th>[ ] APPROVED</th>
<th>[ ] CHANGED</th>
<th>[ ] DENIED</th>
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</thead>
<tbody>
<tr>
<td>DATE</td>
<td>LENGTH OF AUTHORIZATION</td>
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<tr>
<td>MAP PHARMACIST / TECHNICIAN</td>
<td>COMMENTS</td>
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<td>NDC NUMBER</td>
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SUBMIT REQUESTS TO: MAGELLAN MAP DESK FAX: (888) 603-7696 TELEPHONE: (800) 331-4475
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.