AmeriHealth Caritas
New Hampshire

Growth Hormone Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber last name:		Prescriber first name:
Prescriber address:		Prescriber representative:
Specialty:		NPI number:
Phone #:	Fax #:	

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

1. Are the epiphyses open or closed? ☐ Yes ☐ No

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

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.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

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.