



## Service Authorization (SA) Form

## Growth Hormone

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: \_\_\_\_\_

First Name: \_\_\_\_\_

Medicaid ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: ☐ Male ☐ Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

NPI Number: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**DRUG INFORMATION**

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

☐ Endocrinologist ☐ Nephrologist

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

(Form continued on next page.)

Member's Last Name:

Member's First Name:

**CRITERIA**

1. What is the diagnosis?

☐ Idiopathic short stature (ISS)☐ Noonan syndrome (NS)☐ SHOX deficiency (SHOXD)☐ Adult GH deficiency☐ Prader Willi syndrome (PWS)☐ Chronic renal insufficiency☐ Other: \_\_\_\_\_☐ Pediatric growth hormone (GH) deficiency☐ Familial short stature☐ Small for gestational age (SGA)☐ Turner syndrome (TS)☐ Short bowel syndrome (SBS), **skip to diagnosis section**☐ Pediatric chronic kidney disease, **skip to diagnosis section**

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:

Member's First Name:

**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?

☐ 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:

☐ Creatinine clearance of 75 mL/min/1.73 m<sup>2</sup> or less ☐ Dialysis dependency  
☐ Serum creatinine greater than 3.0 g/dL ☐ 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:

Member's First Name:

**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 800-932-6651**, phoned to 800-932-6648, or mailed to:

Prime Therapeutics Management LLC/Attn: GV – 4201

P.O. Box 64811, St. Paul, MN 55164-0811