Iowa Department of Human Services

Request for Prior Authorization
GROWTH HORMONES

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). All of the following criteria must be met for approval for prescribing of growth hormones: 1. Standard deviation of 2.0 or more below mean height for chronological age, 2. No intracranial lesion or tumor diagnosed by MRI, 3. Growth rate below five centimeters per year, 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter. Stimuli testing will not be required for the following diagnoses: Turners Syndrome, chronic renal failure, and HIV/AIDS, 5. Annual bone age testing is required for a diagnosis of growth hormone deficiency. Bone age must be 14 to 15 years or less in females and 15 to 16 years or less in males, 6. Epiphyses open. Prior authorization will be granted for 12-month periods per member as needed. The following FDA approved indication for growth hormone therapy is considered not medically necessary and requests will be denied; Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). If the request is for Zorbtive® [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.

Preferred

- ☐ Norditropin
- ☐ Nutropin AQ Pen
- ☐ Nutropin AQ NuSpin

Non- Preferred

- ☐ Genotropin
- ☐ Humatrope
- ☐ Omnitrope
- ☐ Saizen
- ☐ Tev-Tropin
- ☐ Zorbtive

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges):

_____

Number of vials per month: _____ Estimate length of therapy: _____

Bone Age: _____ Date of Bone Age Test: _____ Epiphyses open? ❑ Yes ❑ No

Height:_____ Weight:_____ Height percentile at time of diagnosis:_____ Weight percentile:_____

Is standard deviation 2.0 or more below mean height for chronological age or less than fifth percentile? ❑ Yes ❑ No

MRI diagnosis: _____ Date:_____

Growth rate per year _____

Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far: _____

_____

Please provide 2 stimuli tests and results:

_____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*