Growth Hormone Agonists

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	

Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:

Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	

Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.

Please identify the indication and medication: *(Preferred Products are in **bold**)*

Pediatric Indications (17 years of age or younger)									
Growth Failure secondary to Chronic Kidney Disease				Nutropin AQ					
Growth Hormone Deficiency	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope	Saizen	Skytrofa	Sogroya	Zomacton
Idiopathic Short Stature	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope				Zomacton
Prader-Willi Syndrome (PWS)	**Genotropin**		**Norditropin**		Omnitrope				
Short Stature associated with Noonan Syndrome			**Norditropin**						
Short Stature Homeobox-containing Gene (SHOX) deficiency		Humatrope							Zomacton
Small Gestational Age (SGA) failed to catch-up growth by age 2	**Genotropin**	Humatrope	**Norditropin**		Omnitrope				Zomacton
Turner Syndrome	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope				Zomacton
Adult Indications (18 years of age or older)									
Growth Hormone Deficiency	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope	Saizen		Sogroya	Zomacton
HIV patients with wasting or cachexia						Saizen	Serostim		
Short Bowel Syndrome									Zorbtive

 Last Updated 7/1/2023

Criteria for Approval (all must be met and documented)

- ❑ Medication is prescribed by or in consultation with a physician who specializes in the disease treatment.
- ❑ Documented diagnosis of requested indication. Chart note #: ________
- ❑ Pediatric patients: documentation of open epiphyses. Chart note #: ________

Additional Criteria for Growth Failure secondary to Chronic Kidney Disease:

- ❑ Member requires weekly dialysis or has a glomerular filtration rate (GFR) <75 ml/min/1.73 m^2
- ❑ **Additional Criteria for HIV-Associated Wasting or Cachexia:** Must be taking antiretroviral medications. Chart note #: ________
- ❑ BMI < 20. BMI: ___________ Chart note #: ________
- ❑ Must not have any untreated or suspected systemic infection or persistent fever > 101 F during the 30 days prior to evaluation of weight loss.
- ❑ Must not have any signs or symptoms of gastrointestinal malabsorption or blockage unless on total parenteral nutrition.
- ❑ Trial and failure of, or contraindication to a preferred appetite stimulant.
  Medication: ____ Chart Note Page #: ________
  Dates of therapy: ____________________ Details of Failure: ________________________________

Additional Criteria for Idiopathic Short Stature:

- ❑ Height standard deviation score (SDS) < -2.25

Additional Criteria for Prader-Willi Syndrome:

- ❑ BMI ≤ 40. BMI: _________ Chart note #: ________
- ❑ No history of sleep apnea, upper airway obstruction, or unidentified respiratory infection. Chart note #: ________
- ❑ Ongoing monitoring for weight control and signs of respiratory infection

Additional Criteria for Short Bowel Syndrome:

- ❑ 18 years of age or older
- ❑ Trial and failure of at least one preferred agent from all the following drug classes:
  - Proton Pump Inhibitor: _________________ Details of failure: ___________________________
  - H2 Antagonist: _________________________ Details of failure: ___________________________
  - Antidiarrheal: __________________________ Details of failure: ___________________________
  - Octreotide: ____________________________ Details of failure: ___________________________

Additional Criteria for Small for Gestational Age that fail to manifest catch-up growth by age 2:
(max covered period is 2 years)

- ❑ 2 years of age or older
- ❑ Diagnosis of small for gestational age (birth weight and/or length of 2 or more standard deviations below the mean for gestational age and gender). Chart note #: ________

Non-Preferred Product: *(Criteria above must also be met)*

- ❑ Trial and failure of preferred Growth Hormone Therapy, per Utah Medicaid's PDL, or prescriber must demonstrate medical necessity for non-preferred product.
  Medication: ____ Chart Note Page #: _________
  Dates of therapy: ____________________ Details of Failure: ________________________________

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_______________________________________ ____________________
Prescriber's Signature Date