

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

GROWTH HORMONE (Children 0-18 years)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX REQUIRED DOCUMENTATION FROM PROGRESS NOTES TO 855-828-4992

CRITERIA for PANHYPOPITUITARISM:

- Approved for ages 0-18, must have started before age 16
- Documented diagnosis of panhypopituitarism

CRITERIA for TURNER SYNDROME:

- Approved for ages 0-18, must have started before age 16
- Documented diagnosis of Turner syndrome

CRITERIA for SMALL GESTATIONAL AGE

- Request must be made before age 3
- Documented diagnosis of small gestational age
- Child has normal GH blood levels (May have documented GH resistance)
- Must be under the care of or have extensive endocrinologist consultation
- A copy of the prescription signed by the physician must be submitted with application

CRITERIA for ALL OTHER COVERED DIAGNOSES

- Approved for ages 0-18, must have started before age 16
- Must have a height stature less than the 5th percentile on the PHYSICAL GROWTH NCHS PERCENTILES CHART for correct age and sex.
- Growth rate must be documented in centimeters for at least 6 months immediately before initiation of growth hormone treatment.
- Prescribed by endocrinologist or with endocrinology consultation.
- **ONE** of the following diagnosis:
 - Documented endogenous growth hormone secretion of <10ng.ml after provocative stimulation **OR**
 - Growth failure associated with documented chronic renal insufficiency up to the time of renal transplantation **OR**
 - Long - term treatment of idiopathic short stature, also called non-growth hormone-deficient short stature, defined by height SDS (Standard Deviation) <2.25 (Humatrope) **OR**
 - Treatment of short bowel syndrome in patients receiving specialized nutritional support
- Patients diagnosed with Prader Willi must complete a sleep oximetry study. If the oximetry is abnormal, a full polysomnography study is required. GH is contraindicated in patients with sleep apnea - PA will not be granted to clients that have sleep apnea.

AUTHORIZATION: 1 year. Maximum covered time period *for small gestational age only* is 2 years.

RE-AUTHORIZATION: Copy of the current prescription, patient's current weight (kilograms), and height (centimeters), and chart-documented regarding from growth in past year. Treated growth rate must exceed untreated rate by 2 centimeters per year (*this last sentence does not apply to patients being treated for small gestational age*).

05/12/11

<https://medicaid.utah.gov/pharmacy/>