pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

GROWTH HORMONES PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **Growth Hormones** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Beneficiary's weight:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
For a non-preferred Growth Hormone: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred drugs in this class that are approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*		☐Yes ☐No *Submit documentation.*	

INITIAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐Beneficiary is a NEONATE:
- ☐Has a diagnosis of growth hormone deficiency confirmed according to current consensus guidelines (eg, Pediatric Endocrine Society)

☐Beneficiary is LESS THAN 18 YEARS OF AGE with OPEN EPIPHYSES:
- ☐For a beneficiary in Tanner stage ≥3, a female beneficiary 12 years of age or older, or a male beneficiary 14 years of age or older:
  - ☐Has epiphyses that are confirmed as open within the previous 6 months
- ☐Had appropriate imaging (MRI or CT) of the brain with particular attention to the hypothalamic and pituitary regions to exclude the possibility of a tumor (not applicable for the following diagnoses: Turner syndrome, Prader-Willi syndrome, or short for gestational age)
- ☐Has growth failure that is not due to idiopathic short stature, familial short stature, or constitutional growth delay
- ☐Had other causes of short stature excluded
- ☐Has a diagnosis of GROWTH HORMONE DEFICIENCY:
  - ☐Diagnosis is confirmed according to current consensus guidelines (eg, Pediatric Endocrine Society)
- ☐Has a diagnosis of INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) DEFICIENCY:
  - ☐Has a height >2.25 standard deviations below the mean for age
  - ☐Has a height >2 standard deviations below the mid-parental height percentile
  - ☐Has a growth velocity below the 25th percentile for bone age
  - ☐Had secondary causes of IGT-1 deficiency excluded (ie, undernutrition and hepatic disease)
  - ☐Has a history of having passed growth hormone stimulation tests

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- ☐ Has a diagnosis of CHRONIC RENAL FAILURE:
  - ☐ Has a diagnosis of pediatric growth failure defined as height >2 standard deviations below the age-related mean due to chronic renal failure
  - ☐ Has not undergone a kidney transplant
- ☐ Has a diagnosis of SHORT FOR GESTATIONAL AGE (SGA):
  - ☐ Was born SGA defined as having weight or length at birth >2 standard deviations below the mean
  - ☐ Was born SGA defined as having weight below the 10th percentile for gestational age
  - ☐ Failed to manifest catch-up growth by 2 years of age defined as height/length ≥2 standard deviations below the mean for age and gender
- ☐ Has a diagnosis of TURNER SYNDROME, NOONAN SYNDROME, OR SHORT STATURE HOMEOBOX (SHOX) SYNDROME:
  - ☐ Has growth failure defined as height >2 standard deviations below the age-related mean due to a diagnosis of Turner syndrome, Noonan syndrome, or SHOX syndrome
- ☐ Has a diagnosis of PRADER-WILLI SYNDROME:
  - ☐ Has a documented diagnosis of Prader-Willi syndrome
  - ☐ Has growth failure defined as height >2 standard deviations below the age-related mean
  - ☐ Does not have symptoms of sleep apnea
  - ☐ Has a history of sleep apnea or symptoms consistent with sleep apnea and has been fully evaluated and treated

☐ Beneficiary is 18 YEARS OF AGE OR OLDER or has CLOSED EPIPHYSES:

- ☐ Has a documented history of adult growth hormone deficiency as a result of:
  - ☐ Childhood-onset growth hormone deficiency
  - ☐ Pituitary or hypothalamic disease
  - ☐ Surgery or radiation therapy
  - ☐ Trauma
- ☐ Diagnosis is confirmed according to current consensus guidelines (eg, American Association of Clinical Endocrinologists)
- ☐ Is currently receiving replacement therapy for any other pituitary hormone deficiencies that is consistent with current medical standards of practice
- ☐ Has a traumatic brain injury or subarachnoid hemorrhage
  - ☐ Has documentation of results of stimulation testing obtained at least 12 months after the date of injury

☐ For the treatment of AIDS-RELATED CACHEXIA:

- ☐ Has a diagnosis of wasting syndrome defined by one of the following:
  - ☐ BMI ≤18.5
  - ☐ Both of the following:
    - ☐ BMI ≤25
    - ☐ Unintentional or unexplained weight loss defined by one of the following:
      - ☐ Weight loss of ≥10% from baseline premorbid weight
      - ☐ BMI <20 in the absence of a concurrent illness or medical condition (other than HIV) that would explain these findings
- ☐ Has wasting syndrome that is not attributable to other causes such as depression, *Mycobacterium avium* complex infection, chronic infectious diarrhea, or malignancy (exception: Kaposi's sarcoma limited to the skin or mucous membranes)
- ☐ Is receiving a comprehensive AIDS treatment that includes antiretrovirals
- ☐ Had an inadequate response to or intolerance of nutritional supplements that increase caloric and protein intake
- ☐ Had an inadequate response to or intolerance of steroid hormones such as megestrol

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Beneficiary is LESS THAN 18 YEARS OF AGE:

- ☐ For a beneficiary in Tanner stage ≥3, a female beneficiary 12 years of age or older, or a male beneficiary 14 years of age or older:
  - ☐ Has epiphyses that are confirmed as open within the previous 6 months
- ☐ Demonstrates a growth response ≥4 cm per year
- ☐ Has not reached expected final adult height (defined as mid-parental height)
- ☐ For a diagnosis of PRADER-WILLI SYNDROME:
  - ☐ Demonstrates improvement in lean-to-fat body mass since starting the requested medication
  - ☐ Demonstrates improvement in growth velocity since starting the requested medication

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☐ Beneficiary is 18 YEARS OF AGE OR OLDER or has CLOSED EPIPHYSES:
- ☐ Demonstrates an increase in total lean body mass since starting the requested medication
- ☐ Demonstrates an increase in exercise capacity since starting the requested medication
- ☐ Demonstrates an improved energy level since starting the requested medication

☐ For the treatment of AIDS-RELATED CACHEXIA:
- ☐ Demonstrates weight stabilization since starting the requested medication
- ☐ Demonstrates weight increase since starting the requested medication

☐ For a DOSE INCREASE:
- ☐ Demonstrates compliance with the requested medication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: