



**GROWTH HORMONE MEDICATIONS**  
 NH Medicaid Prior Authorization  
 Request Form  
 Fax: 1-888-603-7696 Phone: 1-866-675-7755



Date of Medication Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Section I: Patient Information and Medication Requested:**

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

**Section II: Clinical History:**

- Is the prescriber an endocrinologist, nephrologist, or has one been consulted on this case?  Yes  No
- What is the patient's age? \_\_\_\_\_
- What is the patient's height? \_\_\_\_\_
- Is patient a newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism?  Yes  No
- What is the diagnosis/condition being treated with this medication? (or check all that apply) \_\_\_\_\_
 

<input type="checkbox"/> Growth hormone deficiency (pediatric)	<input type="checkbox"/> Growth hormone deficiency (adult onset)	<input type="checkbox"/> Prader-Willi Syndrome
<input type="checkbox"/> Turner Syndrome	<input type="checkbox"/> Renal Insufficiency	<input type="checkbox"/> Chronic Renal Insufficiency
<input type="checkbox"/> Short Bowel Syndrome	<input type="checkbox"/> HIV wasting or cachexia	<input type="checkbox"/> Small for Gestational Age
<input type="checkbox"/> Noonan Syndrome	<input type="checkbox"/> Short Stature Homeobox gene	<input type="checkbox"/> Idiopathic Short Stature

**LAB/TEST RESULTS** (please provide all lab/test results that apply to the condition being treated)

- Are the epiphyses open or closed? \_\_\_\_\_
- What are the results of bone age studies? \_\_\_\_\_
- Is patient's height more than 2 SD below average for population mean height for age and sex?  Yes  No
- Is the patient's height velocity measured over one year to be 1 SD below the mean for chronological age?  Yes  No
- For children over two years of age, has there been a decrease in height SD of more than 0.5 over one year?  Yes  No
- What is the patient's growth hormone response to a provocative stimulation test? (two are required: insulin, levodopa, L-Arginine, clonidine, or glucagon) \_\_\_\_\_ ng/ml
- In adult onset growth hormone deficiency, have the following hormonal deficiencies been ruled out? (check all that apply)
 

<input type="checkbox"/> Thyroid	<input type="checkbox"/> Cortisol	<input type="checkbox"/> Sex Steroids
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**MISCELLANEOUS REQUIRED INFO** (please provide if applicable)

- If being prescribed for AIDS Wasting or cachexia, has the patient had documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace and Marinol)?  Yes  No
- If this is a renewal, has patient had a positive response to therapy?  Yes  No

Please provide information to support a positive response to therapy (i.e. improvements in height, weight, body composition, increased growth velocity, response on growth curve chart). Please provide quantitative improvements. \_\_\_\_\_

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

**Section III: Prescriber Information:**

Print Name: _____	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____
<b>I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.</b>	
_____	
<b>Signature of Prescribing Provider</b>	