

## Growth Hormone for Recipients Under Age 21

**Submit fax request to:** 855-455-3303

**Purpose:** For a prescribing physician to request a prior authorization for growth hormones for a recipient under age 21.

**Questions:** If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

<b>DATE OF REQUEST:</b>		
<b>RECIPIENT INFORMATION</b>		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
<b>PRESCRIBING PROVIDER INFORMATION</b>		
Name:	NPI:	
Phone:	Fax (required):	
Person to contact regarding this request:		
<b>DIAGNOSIS AND REQUESTED DRUG</b>		
Name:	Strength:	
Dosage:	Duration:	
Diagnosis ( <b>REQUIRED</b> ): <input type="checkbox"/> Turner's Syndrome <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Chronic renal insufficiency <input type="checkbox"/> Hypothalamic pituitary disease <input type="checkbox"/> Small for gestational age <input type="checkbox"/> Idiopathic short stature <input type="checkbox"/> Other (document): _____		
<b>COVERAGE CRITERIA</b>		
<b>Please check the applicable boxes to indicate each item as true for the recipient:</b>		
This request is for ( <i>check one</i> ): <input type="checkbox"/> Initial therapy <input type="checkbox"/> Continuing therapy		
The recipient has been evaluated by a: <input type="checkbox"/> Pediatric nephrologist <input type="checkbox"/> Pediatric endocrinologist		
All other causes for short stature have been ruled out. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Epiphyses: <input type="checkbox"/> Open <input type="checkbox"/> Closed		
The recipient has received a renal transplant. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient has deficiencies in three or more pituitary axes (TSH, LH, FSH, ACTH, ADH). <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient is receiving adequate replacement therapy for other hormone deficiencies if required. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient has expanding intracranial lesions or tumor formation. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient's bone age is >2 standard deviations below the mean for age. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient's height is >2.25 standard deviations below mean for age. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient's height is >2 standard deviations below the mid-parenteral height percentile. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient's growth velocity is <25th percentile for bone age or normal height for gender. <input type="checkbox"/> Yes <input type="checkbox"/> No		
The recipient's growth rate on treatment is >2 cm compared to the untreated rate (continuing therapy only). <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please provide information regarding any diagnostic tests or assessments performed:		
<input type="checkbox"/> <b>Growth hormone stimulation test</b>	Date: _____	Level: _____ ng/ml
<input type="checkbox"/> <b>IGF-1</b>	Date: _____	Level: _____ ng/ml
<input type="checkbox"/> <b>IGF-BP3</b>	Date: _____	Level: _____ ng/ml
<input type="checkbox"/> <b>Blood glucose</b>	Date: _____	Level: _____ mg/dl
<b>PROVIDER CERTIFICATION – Prescriber's signature and date required.</b>		
<b>I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.</b>		
<b>Prescriber's Signature:</b> _____		<b>Date:</b> _____

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*