UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

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:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office 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 CKD*				Nutropin AQ						
Growth Hormone Deficiency	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope	Saizen		Skytrofa	Sogroya	Zomacton
HIV patients with wasting or cachexia							Serostim			
Idiopathic Short Stature	**Genotropin**	Humatrope	**Norditropin**	Nutropin AQ	Omnitrope					Zomacton
PWS*	**Genotropin**		**Norditropin**		Omnitrope					

Short Stature associated with Noonan Syndrome			**Norditropin**							
SHOX* deficiency		Humatrope								Zomacton
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							Serostim			

Abbreviations: CKD: Chronic Kidney Disease, PWS: Prader-Willi Syndrome, SHOX: Short Stature Homeobox-containing Gene, SGA: Small Gestational Age

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Criteria for Approval: (*All* of the following criteria must be met):

1. Does the patient have a documented diagnosis of the requested indication? ❑ **Yes** ❑ **No**
2. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment? ❑ **Yes** ❑ **No**
3. If the patient is a pediatric patient, is there documentation of open epiphyses? ❑ **Yes** ❑ **No**

Additional Criteria for Growth Failure secondary to Chronic Kidney Disease:

4. Does the patient require weekly dialysis or have a glomerular filtration rate (GFR) <75 ml/min/1.73 m^2 ? ❑ **Yes** ❑ **No**

Additional Criteria for HIV-Associated Wasting or Cachexia *(Must be taking antiretroviral medications):*

5. Does the patient have a BMI < 20? BMI: _____ ❑ **Yes** ❑ **No**
6. Does the provider attest that the patient does not have any untreated or suspected systemic infections or persistent fever >101°F during the 30 days prior to evaluation of weight loss? ❑ **Yes** ❑ **No**
7. Does the provider attest that the patient does not have any signs or symptoms of gastrointestinal malabsorption or blockage unless on total parenteral nutrition? ❑ **Yes** ❑ **No**
8. Has the patient tried and failed or has a contraindication to a preferred appetite stimulant? ❑ **Yes** ❑ **No**
   Medication: _____ Details of Failure: _____

Additional Criteria for Idiopathic Short Stature:

9. Does the patient have a height standard deviation score (SDS) < -2.25? ❑ **Yes** ❑ **No**

Additional Criteria for Prader-Willi Syndrome:

10. Does the patient have a BMI ≤ 40. BMI: _____ ❑ **Yes** ❑ **No**
11. Does the provider attest that the patient has no history of sleep apnea, upper airway obstruction, or unidentified respiratory infection? ❑ **Yes** ❑ **No**
12. Is the patient receiving ongoing monitoring for weight control and signs of respiratory infection? ❑ **Yes** ❑ **No**

Additional Criteria for Short Bowel Syndrome:

13. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**

14. Has the patient tried and failed at least one preferred agent from all of the following drug classes? ❑ **Yes** ❑ **No**

- ☐ Proton Pump Inhibitor
- ☐ H2 Antagonist
- ☐ Antidiarrheal
- ☐ Octreotide

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

15. Is the patient 2 years of age or older? ❑ **Yes** ❑ **No**
16. Does that patient have a 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)? ❑ **Yes** ❑ **No**

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

17. Has the patient tried and failed a preferred Growth Hormone Therapy, per Utah Medicaid's PDL, or has the prescriber demonstrated medical necessity for a non-preferred product? ❑ **Yes** ❑ **No**
    Medication: _____ Details of Failure: _____

Off Label or Compendia Use of FDA-Approved Drugs Criteria for Approval:

18. Is the request for any off-label or compendia indications that are not listed in the table above? ❑ **Yes** ❑ **No**
19. What is the diagnosis for the request? _____
20. How long is the duration of the treatment requested? _____
21. Has the provider submitted at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System. ❑ **Yes** ❑ **No**

Reauthorization Criteria:

1. Has the patient had clinically significant improvement as shown by the specific appropriate monitoring parameters and/or improvement in symptoms? Chart note page #: _____ ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- Use appropriate HCPCS code for billing:
  Coverage and Reimbursement code lookup: https://health.utah.gov/stplan/lookup/CoverageLookup.php
  HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

PROVIDER CERTIFICATION

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

_____ _____

Prescriber's Signature Date