NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
GROWTH HORMONE (GH) FOR CHILDREN
(Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.)

PRESCRIBING PROVIDER:
Name: _____
First Last
Phone #: (____)-_____
Fax #: (____)-_____
Physician Specialty_____
NPI # _____

MEDICAID RECIPIENT:
Name: _____
First Last
Medicaid #: ☐☐☐☐☐☐☐☐☐☐☐
Date of Birth: ☐☐/☐☐/☐☐☐☐
Other Insurance Information / ID#: _____
(NOTE: Patient must be 18 years or younger.)

PARTICIPATING PHARMACY:
Name: _____
Phone #: (_____)-_____

_____
Fax #: (_____)-_____

DRUG/CLINICAL INFORMATION:

Request Date: _____

☐ **Initial**

Primary Diagnosis:

☐ **Growth hormone deficiency (GHD) associated with chronic kidney disease (CKD),** pre-transplant GFR < 75mL/min: GFR _____ mL/min (CRF only); Dialysis: Y / N ; Transplant : Y / N.

☐ **Documented GH deficiency (GHD) including pituitary dwarfism.**

☐ **Other** (specify) _____

Provocative testing: (Initial GHD Only)
Agent 1 _____ Peak _____ Date _____

Agent 2 _____ Peak _____ Date _____

☐ **Prader-Willi Syndrome (PWS)** diagnostic test: Diagnostic results _____ Attach copy of original study.

☐ **Noonan Syndrome** Attach copy of chart notes or testing.

☐ **SHOX Deficiency** diagnosed by documentation of SHOX gene: SHOX test Results _____ Attach copy of original study.

☐ **Turner's Syndrome (TS)** diagnostic test: Diagnostic results _____ Attach copy of original study.

Date of Most Recent Clinic Visit _____

Diagnostic testing (attach <u>all</u> results):

Physical Stature Percentile _____; Height _____cm; Weight _____kg; Tanner Stage _____.

Bone Age _____Yr _____Mo; Chronological Age _____Yr _____Mo; Date of Scan_____.

Mother's Height _____cm; Father's Height _____cm.

Growth Velocity _____cm/yr

Epiphyses Open: Yes or No (Circle one)
All causes for short stature, other than GH deficiency, ruled out? Yes or No (Circle one)
IGF-1 level & reference range **OR** IGFBP3 level & reference range _____
Thyroid level & reference range _____ Morning Cortisol level & reference range _____
What, if any, hormone replacement therapy, is client receiving: _____

☐ **Dose Change**; Current weight _____

☐ **For Renewal of Therapy:**
Please provide the annual height velocity growth (in centimeters/year) achieved during the previous therapy. _____cm/yr
Please provide the percentage change of growth velocity from baseline. _____%
☐ Yes ☐ No Has final adult height been reached?
☐ Yes ☐ No Have there been any persistent and uncorrectable problems with adherence to treatment?

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. I also attest that I have obtained authorization to release the above information. I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____
(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)
Please note: The Department may request chart documentation to verify the above information.

Submit requests to: **Magellan Medicaid Administration, Inc.** **Fax: 1-866-759-4115**
Tel: 1-800-241-8335