Nebraska Medicaid Program Request for Prior Authorization of Payment
Growth Hormone (GH) for Children | AIDS Wasting/Cachexia for Adults | Short Bowel Syndrome for Adults

Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

OTHER INSURANCE INFORMATION/ID#:

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

PHYSICIAN SPECIALTY:

Participating Pharmacy

NAME: **REQUEST DATE**

PHONE NUMBER: – – **FAX NUMBER:** – –

DRUG REQUESTED

NAME: **STRENGTH:** **DAILY DOSE:**

Drug/Clinical Information for Growth Hormone for Patients < 18 Years of Age

☐ Initial

☐ Dose Change Current Weight: _____

☐ Renewal

Growth velocity (cm/yr.): Current: _____ Pre-Treatment: _____ Compliant with GH therapy? ☐ Yes ☐ No

Percentage change of growth velocity from baseline: _____ %

Has final adult height been reached? ☐ Yes ☐ No

Have there been any persistent and uncorrectable problems with adherence to treatment? ☐ Yes ☐ No

Renewal may be denied for non-compliance with growth hormone therapy and/or failure to demonstrate a current growth rate at least 2 cm/yr. > pre-treatment growth rate.

Fax this form to 866-759-4115
or mail to
Prime Therapeutics State Government Solutions LLC, MAP Dept., Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Tel: 1-800-241-8335

Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.

Primary Diagnosis:

☐ **Growth hormone deficiency (GHD) associated with chronic kidney disease (CKD)**, pre-transplant GFR < 75 mL/min:
GFR _____ mL/min (CRF only) Dialysis: ☐ Yes ☐ No Transplant: ☐ Yes ☐ No

☐ **Turner's Syndrome (TS)** diagnosed by karyotyping: Karyotype Results: _____ Attach copy of original study

☐ **Prader-Willi Syndrome (PWS)** diagnosed by karyotyping: Karyotype 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

☐ **Other** (specify): _____

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

Diagnostic Testing (attach all results):

Date of most recent clinic visit: _____

Physical stature percentile: _____ Height: _____ cm Weight: _____ kg Tanner stage: _____

Chronological age: _____ Yr. _____ Mo.

* If the patient's chronological age is 5 years or older, complete the following bone age and date of scan:

Bone age: _____ Yr. _____ Mo. Date of scan: _____

Mother's height: _____ cm Father's height: _____ cm Growth velocity: _____ cm/yr.

Epiphyses open: ☐ Yes ☐ No

All causes for short stature other than GH deficiency ruled out? ☐ Yes ☐ No

Provocative testing: (Initial GHD Only)

Agent 1: _____ Peak: _____ Date: _____

Agent 2: _____ Peak: _____ Date: _____

Thyroid level and reference range _____ _____

What, if any, hormone replacement therapy is client receiving:

Drug/Clinical Information for Growth Hormone for Patients ≥ 18 Years of Age

☐ **AIDS Wasting/Cachexia**

☐ Weight loss of > 10% over a 12-month period

Baseline weight and date: _____ Current weight and date: _____

Does patient have concurrent illness other than HIV infection contributing to weight loss? ☐ Yes ☐ No

Current antiretroviral treatment that will be continued concomitantly, please list (drug name, strength, and dosage):

_____

☐ Please attach documentation of at least a 12-week trial of dronabinol and/or megestrol within the previous year.

☐ **For Renewal of Therapy**: Must provide documentation of a clinical response to therapy with either a stable maintenance of or an increase in body weight.

☐ **Short Bowel Syndrome**

☐ Please provide documentation that the patient is receiving specialized nutritional support

☐ Prescribed by OR in consultation with a gastroenterologist

***Approval for Zorbtive (somatropin) will be for a maximum of 4 weeks per calendar year.**

Fax this form to 866-759-4115
or mail to
Prime Therapeutics State Government Solutions LLC, MAP Dept., Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Tel: 1-800-241-8335

Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.

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 (Required)	***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.

Fax this form to 866-759-4115

or mail to

Prime Therapeutics State Government Solutions LLC, MAP Dept., Attn: GV – 4201

P.O. Box 64811

St. Paul, MN 55164-0811

Tel: 1-800-241-8335