NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
INSULIN-LIKE GROWTH FACTOR (IGF) FOR CHILDREN

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**

☐ **Renewal:** Growth velocity (cm/yr): Current _____; Pre-treatment _____. Compliant with IGF therapy: Y / N.

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

Drug Requested _____ Strength _____ Daily dose _____

Primary Diagnosis:

☐ **Primary Insulin-Like Growth Factor (IGF-1) Deficiency (IGFD)**

Height Standard Deviation Score: _____ _____Basal IGF-1 Standard Deviation Score: _____

IGF-1 level & reference range _____

Provocative testing: (Initial Request Only)

Agent 1 _____ Peak _____ Date _____

Agent 2 _____ Peak _____ Date _____

☐ **Growth Hormone Gene Deletion with Neutralizing Antibodies to GH**

☐ **Other** (specify) _____

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_____.

Open epiphyses: Y / N

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

Growth Velocity _____cm/yr

Thyroid level & reference range _____ ACTH level & reference range _____

What, if any, hormone replacement therapy, is patient receiving:_____

Attach growth chart, showing trend over a minimum of the past 3 years.

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:** _____

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