

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
GROWTH HORMONE (Children 0-18 years)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext and options _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____
Diagnosis _____

All information to be legible, complete and correct or form will be returned

FAX REQUIRED DOCUMENTATION FROM PROGRESS NOTES TO (801) 536-0477

CRITERIA:

- ▶ Approved for ages 0-18, must have started before age 16.
- ▶ Must have a height stature less than the 5th percentile on the PHYSICAL GROWTH NCHS PERCENTILES CHART for correct age and sex.
- ▶ Growth rate must be documented in centimeters for a least 6 months immediately before initiation of growth hormone treatment.
- ▶ **ONE** of the following diagnosis:
 - *Documented endogenous growth hormone secretion of <10ng.ml after provocative stimulation OR
 - *Growth failure associated with documented chronic renal insufficiency up to the time of renal OR transplantation.
 - *Long - term treatment of idiopathic short stature, also called non-growth hormone-deficient short stature, defined by height SDS (Standard Deviation) <2.25 (Humatrope) OR
 - *Treatment of short stature associated with Turner Syndrome in patients whose epiphysis are not closed OR
 - *Treatment of short bowel syndrome in patients receiving specialized nutritional support OR
 - *Panhypopituitarism
- ▶ Completed sleep oximetry study for clients with Prader Willi. If the oximetry is abnormal, a full polysomnography study is required. GH is contraindicated in patients with sleep apnea - PA will not be granted to clients that have sleep apnea.
- ▶ Prescribed by endocrinologist or with endocrinology consultation.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Fax pt's wt in kilograms, ht. in centimeters, and current prescription. Treated growth rate must exceed untreated rate by 2 centimeters per year.

CRITERIA: Section II SMALL GESTATIONAL AGE (SGA)

- ▶ Request must be made before age three
- ▶ Child has normal GH blood levels (May have documented GH resistance)
- ▶ Must be under the care of or have extensive endocrinologist consultation.
- ▶ A copy of the prescription signed by the physician must be submitted with application.

AUTHORIZATION:

1 year. Maximum covered time period: 2 years

RE-AUTHORIZATION:

Fax copy of current prescription and history and physical showing growth in past year.