



GROWTH HORMONES, SOMATROPIN AGENTS PRIOR AUTHORIZATION

RETURN TO: ATTN: DRUG PRIOR AUTHORIZATION
MO HEALTHNET DIVISION
PO BOX 4900
JEFFERSON CITY, MO 65102-4900

Please print or type. All information must be supplied or the request will not be processed. For drug specific requirements or questions, call (800) 392-8030. Submit completed form by fax to (573) 636-6470.

Participant Information

Participant Name	<input type="checkbox"/> Initial Request <input type="checkbox"/> Renewal Request
Participant MO HealthNet Number	Date of Birth

Requested Drug and Diagnosis Information

Requested Drug Name	Requested Drug Strength, Dosing Form and Directions
<input type="checkbox"/> Genotropin	
<input type="checkbox"/> Genotropin MiniQuick	
<input type="checkbox"/> Norditropin FlexPro	
<input type="checkbox"/> Other, Specify	

What is the duration of need for the medication?

What is the diagnosis for use of this drug?	ICD-10 Code
---------------------------------------------	-------------

List all other related medications previously tried, including dose, schedule, duration and dates of use

Submit Documentation of any of the Following Labs Results (If applicable)

Baseline Height		Date		Current Height		Date		IGF-11 Level		Date	
Baseline Height		Date		Current Height		Date		IGF-1 SDS		Date	
Baseline BMI		Date		Current BMI		Date		Height SDS		Date	

Submit the following documentation (e.g., office progress notes, labs, testing, etc.) as determined by the participant's age and diagnosis

Adult Criteria (≥18 years of age)

Diagnosis of HIV with wasting or cachexia	Diagnosis of growth hormone deficiency	Other diagnoses
<input type="checkbox"/> Documentation of baseline BMI < 20g/m ² <input type="checkbox"/> Documented unintentional weight loss of more than 5% body weight in the past 6 months <input type="checkbox"/> Compliance on antiretroviral therapy <input type="checkbox"/> One month therapeutic trial of dronabinol OR megestrol acetate in the past year	<input type="checkbox"/> Documentation of growth hormone deficiency with low serum insulin-like growth factor-1 (IGF-1) defined as below -1 SDS AND failure of 1 GH simulation test OR <input type="checkbox"/> Failure or 2 GH stimulation tests: <ul style="list-style-type: none">• Insulin Tolerance Test (ITT) OR• GH Stimulation Panel w/ arginine, glucagon, propranolol or levodopa OR• Equivalent Diagnostic Test	<input type="checkbox"/> Documented diagnosis of cardiomyopathy OR short bowel syndrome

Pediatric Criteria (<18 years of age)		
Diagnosis in the past 2 years of one of the following		Documentation of growth failure in the past 2 years defined as one of the following
<input type="checkbox"/> Prader-Willi Syndrome confirmed with baseline polysomnography results and confirmed generic testing OR <input type="checkbox"/> Turner Syndrome confirmed by chromosome analysis OR <input type="checkbox"/> Noonan Syndrome confirmed with genetic testing OR <input type="checkbox"/> Short stature homeobox-containing gene (SHOX) deficiency confirmed with genetic testing		<input type="checkbox"/> Height SDS more than 3 SDS below the mean for chronological age and sex OR <input type="checkbox"/> Growth velocity measured over 1 year -2 SDS below the mean for chronological age and sex OR <input type="checkbox"/> Height SDS between -2 and -3 below the mean for chronological age and sex AND growth velocity measured over 1 year below 25 th percentile for age and sex AND <input type="checkbox"/> Documentation of gender-specific delayed bone age (initial requests only) <input type="checkbox"/> X-rays without the presence of epiphyseal closure for participants 15 years of age and older PLUS For diagnosis of Growth Hormone Deficiency <input type="checkbox"/> Low serum IGF-1 defined as below -1 SDS AND failure of 1 GH stimulation test OR <input type="checkbox"/> Failure of 2 GH stimulation tests: <ul style="list-style-type: none"> • Insulin Tolerance Test (ITT) OR • GH Stimulation Panel w/ arginine, glucagon, propranolol or levodopa OR • Other Equivalent Diagnostic Test
Diagnosis of chronic renal insufficiency/ chronic kidney disease (CKD)	Diagnosis of child being born small for gestational age	Diagnosis in the past 2 years of idiopathic short stature
<input type="checkbox"/> Lack of renal transplant in the past year	<input type="checkbox"/> Children currently aged 2-4 years	<input type="checkbox"/> Lack of other identifiable causes (i.e. hypothyroidism, chronic illness, undernutrition or genetic disorders)
Prescriber Information		
Prescriber name and specialty		Prescriber Provider NPI
Prescriber Telephone Number	Prescriber Fax Number	
Prescriber Other contact info:		
Name of person completing form	Title and credentials of person completing form	
Telephone Number of person completing form	Fax Number of person completing form	
Other contact info of person completing form:		
Signature of person completing form		Date