MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

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.
PHONE: (800) 392-8030 FAX: (573) 636-6470

PARTICIPANT NAME	PARTICIPANT MO HEALTHNET NUMBER
☐ INITIAL REQUEST ☐ RENEWAL REQUEST WHAT IS THE DURATION OF NEED FOR THE MEDICATION? _____	DATE OF BIRTH

REQUESTED DRUG NAME, DOSAGE FORM, STRENGTH, AND DOSING SCHEDULE

- ☐ Genotropin
- ☐ Genotropin MiniQuick
- ☐ Norditropin FlexPro
- ☐ Other (Please Specify)

DIAGNOSIS FOR USE OF THIS DRUG (INCLUDING ICD-10 CODE)

LIST ALL OTHER RELATED MEDICATIONS PREVIOUSLY TRIED, INCLUDING DOSE, SCHEDULE, LENGTH AND DATES OF PRODUCT USE

PLEASE SUBMIT DOCUMENTATION OF ANY OF THE FOLLOWING LAB RESULTS (IF APPLICABLE)

BASELINE HEIGHT: _____ DATE: _____ CURRENT HEIGHT: _____ DATE: _____ IGF-1 LEVEL: _____ DATE: _____

BASELINE WEIGHT: _____ DATE: _____ CURRENT WEIGHT: _____ DATE: _____ IGF-1 SDS: _____ DATE: _____

BASELINE BMI: _____ DATE: _____ CURRENT BMI: _____ DATE: _____ HEIGHT SDS: _____ DATE: _____

PLEASE 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)

i. For diagnosis of HIV with wasting or cahexia:

- ☐ Documentation of baseline BMI < 20g/m²
- ☐ Documented unintentional weight loss of more than 5% body weight in the past 6 months
- ☐ Compliance on antiretroviral therapy
- ☐ One month therapeutic trial of dronabinol OR megestrol acetate in the past year

ii. For diagnosis of growth hormone deficiency:

- ☐ Documentation of growth hormone deficiency with low serum insulin-like factor-1 (IGF-1) defined as below -1 SDS AND failure of 1 GH stimulation test OR
- ☐ Failure of 2 GH stimulation tests:
  - Insulin Tolerance Test (ITT) OR
  - GH Stimulation Panel w/ arginine, glucagon, propranolol or levodopa OR
  - Equivalent Diagnostic Test

iii. For other diagnoses:

- ☐ Documented diagnosis of cardiomyopathy OR short bowel syndrome

PLEASE SUBMIT THE FOLLOWING DOCUMENTATION (E.G. OFFICE PROGRESS NOTES, LABS, TESTING, ETC) AS DETERMINED BY THE PARTICIPANT'S AGE AND DIAGNOSIS:

Pediatric Criteria (<18 years of age)

i. Diagnosis in the past 2 years of one of the following:

☐ Prader-Willi Syndrome confirmed with baseline polysomnography results and confirmed genetic testing OR
☐ Turner Syndrome confirmed by chromosome analysis OR
☐ Noonan Syndrome confirmed with genetic testing OR
☐ Short stature homeobox-containing gene (SHOX) deficiency confirmed with genetic testing

OR

ii. Diagnosis of growth failure in the past 2 years defined as one of the following:

☐ Height SDS more than 3 SDS below the mean for chronological age and sex OR
☐ Growth velocity measured over 1 year -2 SDS below the mean for chronological age and sex OR
☐ Height SDS between -2 and -3 below the mean for chronological age and sex AND growth velocity measured over 1 year below 25th percentile for age and sex

AND

☐ Documentation of gender-specific delayed bone age (initial requests only)
☐ X-rays without the presence of epiphyseal closure for participants 15 years of age and older

PLUS

☐ Low serum IGF-1 defined as below -1 SDS AND failure of 1 GH stimulation test OR
☐ Failure of 2 GH stimulation tests:
- Insulin Tolerance Test (ITT) OR
- GH Stimulation Panel w/ arginine, glucagon, propranolol or levodopa OR
- Other Equivalent Diagnostic Test

OR

iii. For diagnosis of chronic renal insufficiency/chronic kidney disease (CKD):

☐ Lack of renal transplant in the past year

OR

iv. For diagnosis of child being born small for gestational age:

☐ Children currently aged 2-4 years

OR

v. For diagnosis in the past 2 years of idiopathic short stature:

☐ Lack of other identifiable causes (i.e. hypothyroidism, chronic illness, undernutrition or genetic disorders)

REQUESTING PHYSICIAN OR ADVANCED PRACTICE NURSE NAME AND TITLE	TELEPHONE NUMBER	FAX NUMBER
ADDRESS	PROVIDER SPECIALTY	PROVIDER NPI
PHYSICIAN'S OR APN'S SIGNATURE (ORIGINAL) AND TITLE		DATE SIGNED