Growth Hormone Prior Authorization Form

for members under 21 years of age

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (Credentials)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name | Strength | Route of Administration

Directions | Diagnosis | ICD Diagnosis Code (if available)

Diagnosis: Please choose only one of the following diagnosis areas:

- ☐ Growth Hormone Deficiency
- ☐ Neurosecretory Growth Retardation
- ☐ Growth Retardation due to Chronic Renal Insufficiency
  - Does the patient have an irreversible renal insufficiency with a creatinine clearance rate of less than 75 ml/min per 1.7 m^2 (pre-renal transplant?) ☐ Yes ☐ No (not approved)
- ☐ Idiopathic Short Stature — Father's Height (in cm): | Mother's Height (in cm):
- ☐ Small for Gestational Age — Gestational Age at Birth: | Birth Weight (in kg): | Birth Length (in cm):
- ☐ Turner Syndrome
- ☐ Prader-Willi Syndrome
- ☐ SHOX Syndrome
- ☐ Noonan Syndrome

Updated 1/12/2026

Initial Authorization:

Current Height (in cm)	Current Weight (in kg)	Current Bone Age *(please attach)*	Date of X-Ray

Epiphyses open? ☐ Yes ☐ No (not approved) | Expanding intracranial lesions or tumors? ☐ Yes (not approved) ☐ No

Growth hormone (GH) stimulus test results: *At least two tests required. Please attach lab results.*

Date of test:	Stimulus agent given:	Peak growth hormone level (ng/mL):
Date of test:	Stimulus agent given:	Peak growth hormone level (ng/mL):

Current growth velocity (cm/year) *(please attach growth chart)*	Standard deviation from mean height for chronological age	IGF-1 level *(please attach lab)*	Tanner scale rating

If requesting a non-preferred product, please provide details of previous trials on preferred products (medication name, dose/directions, trial date range, & reason for discontinuing) or otherwise describe the reason(s) the patient cannot be treated with a preferred product.

Other pertinent Information (attach additional pages if necessary)

Continuation of Treatment:

Current Height (in cm)	Current Weight (in kg)	Current Bone Age *(please attach)*	Date of X-Ray

Epiphyses open? ☐ Yes ☐ No (not approved) | Expanding intracranial lesions or tumors? ☐ Yes (not approved) ☐ No

Current growth velocity (cm/year) *(please attach growth chart)*	Standard deviation from mean height for chronological age	IGF-1 level *(please attach lab)*	Tanner scale rating

If requesting a non-preferred product, please provide details of previous trials on preferred products (medication name, dose/directions, trial date range, & reason for discontinuing) or otherwise describe the reason(s) the patient cannot be treated with a preferred product.

Other pertinent Information (attach additional pages if necessary)

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)