



## Growth Hormone Prior Authorization Form

for members under 21 years of age

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)

**Confidentiality Notice:** This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents. Thank you.

**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 <sup>2</sup> (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			

**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: <i>At least two tests required. Please attach lab results.</i>					
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) <i>(please attach growth chart)</i>	Standard deviation from mean height for chronological age	IGF-1 level <i>(please attach lab)</i>	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)					
<b>Continuation of Treatment:</b>					
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) <i>(please attach growth chart)</i>	Standard deviation from mean height for chronological age	IGF-1 level <i>(please attach lab)</i>	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)