



Growth Hormone for Recipients Under Age 21

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:		
MEMBER INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Molina ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:		NPI:
Phone:		Fax (required):
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:		Strength:
Dosage:		Duration:
Diagnosis (REQUIRED):		
<input type="checkbox"/> Turner's Syndrome <input type="checkbox"/> Prader-Willi Syndrome <input type="checkbox"/> Chronic renal insufficiency <input type="checkbox"/> Hypothalamic pituitary disease <input type="checkbox"/> Small for gestational age <input type="checkbox"/> Idiopathic short stature <input type="checkbox"/> Other (document): _____		
COVERAGE CRITERIA		

Please check the applicable boxes to indicate each item as true for the recipient:

This request is for (check one): Initial therapy Continuing therapy

The recipient has been evaluated by a: Pediatric nephrologist Pediatric endocrinologist

All other causes for short stature have been ruled out. Yes No

Epiphyses: Open Closed

The recipient has received a renal transplant. Yes No

The recipient has deficiencies in three or more pituitary axes (TSH, LH, FSH, ACTH, ADH). Yes No

The recipient is receiving adequate replacement therapy for other hormone deficiencies if required. Yes No

The recipient has expanding intracranial lesions or tumor formation. Yes No

The recipient's bone age is >2 standard deviations below the mean for age. Yes No

The recipient's height is >2.25 standard deviations below mean for age. Yes No

The recipient's height is >2 standard deviations below the mid-parental height percentile. Yes No

The recipient's growth velocity is <25th percentile for bone age or normal height for gender. Yes No

The recipient's growth rate on treatment is >2 cm compared to the untreated rate (continuing therapy only). Yes No

Please provide information regarding any diagnostic tests or assessments performed:

<input type="checkbox"/> Growth hormone stimulation test	Date: _____	Level: _____ ng/ml
<input type="checkbox"/> IGF-1	Date: _____	Level: _____ ng/ml
<input type="checkbox"/> IGF-BP3	Date: _____	Level: _____ ng/ml
<input type="checkbox"/> Blood glucose	Date: _____	Level: _____ mg/dl

PROVIDER CERTIFICATION – Prescriber's signature and date required.

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ Date: _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.