**MOLINA HEALTHCARE**
**Service Authorization (SA) Form**
**GROWTH HORMONE**

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

## MEMBER INFORMATION

**Last name:**

**First name:**

**Medicaid ID number:**

**Date of birth:** ___ – ___ – ____

**Gender:** ☐ **Male** ☐ **Female**

## PRESCRIBER INFORMATION

**Last name:**

**First name:**

**NPI number:**

**Phone number:** ___ – ___ – ____

**Fax number:** ___ – ___ – ____

**Is the drug prescribed by or in consultation with a specialty?**

☐ Endocrinologist ☐ Nephrologist

## DRUG INFORMATION

**Drug name/Form:** _____

**Strength:** _____

**Quantity per day:** _____

**All growth hormone medications require the submission of a Clinical Service Authorization**

**Preferred medications:**

☐ **Genotropin®** ☐ **Norditropin FlexPro®**

**Non-Preferred medications:**

☐ *Humatrope® cartridge/vial* ☐ *Nutropin AQ® NuSpin®* ☐ *Nutropin AQ® cartridge/vial*

☐ *Omnitrope® cartridge/vial* ☐ *Saizen® cartridge/vial* ☐ *Serostim® vial*

☐ *Skytrofa™ Syringe* ☐ *Zomacton® vial* ☐ *Zorbtive® vial*

**If requesting a non-preferred agent, please document why a preferred agent cannot be used:**

*(Form continued on next page.)*


Revised: 3/17/22 | Effective: 07/15/2022

**Member's last name:** **Member's first name:**

## CRITERIA

1. What is the diagnosis?
   - ☐ Idiopathic short stature (ISS)
   - ☐ Noonan syndrome (NS)
   - ☐ SHOX deficiency (SHOXD)
   - ☐ Adult GH deficiency
   - ☐ Prader Willi syndrome (PWS)
   - ☐ Chronic renal insufficiency
   - ☐ Pediatric growth hormone (GH) deficiency
   - ☐ Familial short stature
   - ☐ Small for gestational age (SGA)
   - ☐ Turner syndrome (TS)
   - ☐ Short bowel syndrome (SBS), ***skip to diagnosis section***
   - ☐ Pediatric chronic kidney disease, ***skip to diagnosis section***
   - ☐ Other: _____
2. Is this request for a new start, restart (re-initiation) or continuation of Growth Hormone (GH) therapy?
   - ☐ New start, ***skip to diagnosis section***
   - ☐ Restart, ***skip to diagnosis section***
   - ☐ Continuation
3. Is the member's growth velocity at least 2 cm per year while on GH therapy?
   - ☐ Yes ☐ No

   **Action required:** *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year.*
4. Are the growth plates open?
   - ☐ Yes ☐ No
5. What is the member's current height? Age: Years _____ Months _____ Height: _____ inches

   **Action required:** *Please attach documentation from the medical record of current height.*

## DIAGNOSIS AND MEDICAL INFORMATION

**Complete the following section(s), based on the Member's diagnosis. Complete all that apply:**

**Section A: All pediatric indications**

6. What is the member's pretreatment height and age?
   Age: Years _____ Months _____ Height: _____ inches

   **Action required:** *Please attach documentation from the medical record showing pretreatment height and age at measurement.*
7. Which of the following criteria does the member's pretreatment height meet?
   - ☐ Greater than or equal to 2.25 standard deviations (SD) below the mean for age and gender
   - ☐ Greater than or equal to 2 standard deviations (SD) below the mean for age and gender

*(Form continued on next page.)*

**Member's last name:** **Member's first name:**

8. What is the member's pretreatment growth velocity?
   - ☐ Greater than 1 standard deviation (SD) below the mean for age and gender
   - ☐ 1 SD below the mean for age and gender

   **Action required:** *Please attach documentation from the medical record showing either.*
   - ☐ At least 2 heights measured by an endocrinologist at least 6 months apart (data for at least 1 year)
   - ☐ At least 4 heights measured by a primary care physician at least 6 months apart (data for at least 2 years)

**Section B: Pediatric GH Deficiency**

9. Did the member have a GH response of less than 10 ng/mL (or otherwise abnormal as determined by the lab) of at least 2 GH stimulation tests LFTs?

   ☐ Yes ☐ No

   **Action required:** *If YES, please attach documentation of stimulation test results.*

10. Did member have a GH response of less than 15 ng/mL on at least 1 GH stimulation test?

    ☐ Yes ☐ No

    **Action required:** *Please attach documentation of GH stimulation test result. If YES, indicate results.*

11. Does the member have a defined CNS pathology, history of cranial irradiation or genetic condition associated GH deficiency?

    ☐ Yes ☐ No

12. Does the member have both IGF-1 and IGFBP-3 levels below normal for age and gender?

    ☐ Yes ☐ No

    **Action required:** *If YES, please attach documentation from the medical record showing IGF-1 and IGFBP-3 levels below normal.*

13. Does the member have 2 or more documented pituitary hormone deficiencies other than GH?

    ☐ Yes ☐ No

14. Did the member have an abnormally low GH level in association with neonatal hypoglycemia?

    ☐ Yes ☐ No

    **Action required:** *If YES, please attach documentation of GH level.*

**Section C: Pediatric Chronic Kidney Disease/Chronic Renal Insufficiencies**

15. Does the member have any of the following? Indicate any/all the apply:
    - ☐ Creatinine clearance of 75 mL/min/1.73 m2 or less
    - ☐ Dialysis dependency
    - ☐ Serum creatinine greater than 3.0 g/dL
    - ☐ None of the above

*(Form continued on next page.)*

**Member's last name:** **Member's first name:**

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**Section D: Pediatric Chronic Kidney Disease**

16. Is this request for a new start, restart (re-initiation) or continuation of GH therapy?
    ☐ New start, *no further questions* ☐ Restart ☐ Continuation
17. Was GH therapy previously approved for this member?
    ☐ Yes ☐ No
18. What is the member's current height in inches? _____

    **Action required:** *Please attach documentation from the medical record of current height.*

    *If Restart, no further questions.*
19. Is the member's growth velocity at least 2 cm per year while on GH therapy?
    ☐ Yes ☐ No

    **Action required:** *If YES, please attach documentation from medical record supporting growth velocity of at least 2 cm/year. (Form continued on next page.)*

**Section E: Adult GH Deficiency**

20. Does the member have irreversible hypothalamic/pituitary structural lesions or ablation?
    ☐ Yes ☐ No ***If YES, no further questions.***
21. Does the member have a defect in GH synthesis?
    ☐ Yes ☐ No ***If YES, no further questions.***
22. Did the member have GH deficiency diagnosed during childhood?
    ☐ Yes ☐ No
23. Does the member have 3 or more pituitary hormone deficiencies?
    ☐ Yes ☐ No
24. Was the member retested for GH deficiency after an at least 1-month break in GH therapy?
    ☐ Yes ☐ No
25. Which of the following pharmacologic agents was used in a GH stimulation test to measure peak GH levels?
    ☐ Insulin ☐ Clonidine ☐ Levodopa ☐ Glucagon ☐ Arginine
    ☐ GH stimulation test not performed ☐ Other: _____

    **Action required:** *Please attach documentation showing the results of GH stimulation test.*
26. Indicate the peak GH level: _____ ng/mL
27. Is the pretreatment IGF-1 level below the laboratory's range of normal?
    ☐ Yes ☐ No

    **Action required:** *Please attach documentation from the medical record showing the member's pretreatment IGF-1 level.*

*(Form continued on next page.)*

**Member's last name:** **Member's first name:**

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**Section F: Short Bowel Syndrome**

28. Is the member receiving specialized nutritional support?

☐ Yes ☐ No

29. Will GH be used in conjunction with optimal management of short bowel syndrome?

☐ Yes ☐ No

30. How many months of GH therapy has the member received? _____ months

☐ Not applicable/New start

**Prescriber signature (Required)** **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; incomplete forms will delay the SA process.**
Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **faxed to 1-844-278-5731**, or you may call **(800) 424-4518. (TTY: 711)**