Growth Hormone Prior Authorization Form

for members under 21 years of age

West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

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) | (MI)

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

(State): West Virginia

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

Pharmacy Name (if applicable)

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

(State): West Virginia

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)

Initial Authorization: All products in this category, whether preferred or non-preferred, require prior authorization. If the requested agent is non-preferred, the Preferred Drug List Prior Authorization Form must be completed in addition.

Current Height (in cm) | Current Weight (in kg) | Current Bone Age | Date of X-Ray

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

Date of GH stimulus test: | Test type: | Results (ng/ml)

IFG-1 level (percentile for chronological age) | Standard deviation from mean for chronological age (growth chart is required) | Tanner Scale Rating:

Please choose only one of the following diagnosis areas:

☐ Growth Hormone Deficiency

☐ Neurosecretory Growth Retardation

☐ Turner's Syndrome (attach documentation, required)

☐ 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)

☐ Non-Growth Hormone Deficiency (Idiopathic short stature)

Father's Height (in cm) | Mother's Height (in cm)

Is the child's ability to participate in the basic activities of daily living limited by his/her height? ☐ Yes (explain) ☐ No (not approved)

☐ Other

Other pertinent Information (attached additional pages if necessary)

Continuation of Treatment: All products in this category, whether preferred or non-preferred, require prior authorization. If the requested agent is non-preferred, the Preferred Drug List Prior Authorization Form must be completed in addition.

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

Epiphyses open? ☐ Yes ☐ No (not approved)

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

Current rate of growth (cm/past 12 months) growth chart is required

Tanner Scale Rating:

Other pertinent Information (attached additional pages if necessary)

☐ I am a board certified pediatric endocrinologist

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)