Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

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Montana Healthcare Programs Prior Authorization for use of Growth Hormones

(Preferred Growth Hormones: Norditropin® and Genotropin®)

Member Information			
Name:		Name:	
DOB:	Gender:	Specialty:	
Member ID #:		Phone:	Fax:
Requested Drug Name/Dosage Form/Strength:		Office Contact for Request:	

Please complete information below and ATTACH ALL SUPPORTING DOCUMENTATION for applicable situation,
Initiation *or* Continuation *of therapy (updates required annually):*

☐ INITIATION OF THERAPY Please indicate diagnosis:

☐Growth hormone deficiency (GHD)-pediatric ☐Prader-Willi syndrome ☐Noonan syndrome
☐Growth hormone deficiency (GHD)-adult ☐Turner syndrome (females only) ☐Short bowel syndrome
☐Chronic renal insufficiency (with estimated GFR < 75 ml/min–Provide eGFR: _____ml/min) ☐HIV/AIDS wasting or cachexia
☐Small for gestational age (SGA) ☐Other: _____
(Note: Diagnosis of Idiopathic Short Stature (ISS) requires proof of medical necessity with supporting documentation detailing how the condition is adversely affecting the members's physical health).

1. Medication is being prescribed by, or in consult with, an endocrinologist: ☐Yes ☐No
   Action Required: If not in a specialty clinic or written by a specialist, information on annual consult with the appropriate specialist is required:

   Name of Specialist: _____ Contact Date: _____

2. Has a brain MRI been performed to exclude the possibility of an intracranial lesion/tumor? ☐Yes ☐No ☐N/A

   If no MRI performed, provide rationale: _____

3. Is member's height more than 2SD below mean height (or wt if SGA) for chronological age? ☐Yes ☐No ☐ N/A (adult)
   IF SGA, has member failed to achieve catch-up growth by age 2? (attach growth chart) ☐Yes ☐No

4. Is the member's growth velocity < 5 cm/year? ☐Yes ☐No ☐N/A (adult)
   Growth velocity: _____ Date: _____

5. Is bone age <14-15 years (female); <15-16 years (male)? ☐Yes ☐No ☐N/A-adult Epiphyses are: ☐Open ☐Closed ☐ N/A-adult

6. **IF GHD (Pediatric):** TWO provocative GH stimulation tests (must be <10 ng/ml) required unless known pathology of CNS, h/o irradition, other pituitary defects, or other genetic condition associated with GHD (only ONE stimulation test required):
   Test 1: type_____ Peak GH Value: _____ng/ml Date: _____
   Test 2: type_____ Peak GH Value: _____ng/ml Date: _____

   If only one test submitted, provide rationale:_____

7. **IF GHD (Adult):**
☐ Adult with history of pediatric GHD or adult onset with hypothalamic or pituitary disease and at least **one** other pituitary hormone deficiency *requiring replacement*: Provide IGF-1 level and **one** GH stimulation test result:
IGF-1 level: ____ ng/ml *Normal IGF-1 range:* _____*ng/ml* GH Stimulation Test type_____
Peak GH Value: _____ng/ml
☐ Adult onset with hypothalamic or pituitary disease and documented panhypopituitarism *requiring replacement*?
☐Yes ☐No IGF-1 level required:_____ng/ml *Normal IGF-1 range:* _____*ng/ml*

Indicate current hormone replacement therapies: _____

8. **IF Turner Syndrome (Females only):**
- Is the member's height below the fifth percentile for age on the normal female growth chart? ☐Yes ☐No
Current Height: _____ Date: _____

- Is bone age <14-15 years? ☐Yes ☐No Epiphyses are: ☐Open ☐Closed

9. Please provide any additional pertinent information if necessary (i.e., reason for request of non-preferred drug, etc.):
_____

☐ **CONTINUATION OF THERAPY UPDATE** (Information below required for pediatric GH deficiency, chronic renal insufficiency, Prader-Willi/Turner/Noonan syndrome and SGA. Update only required for other diagnoses).

1. **Bone age must be <14-15 years (female); <15-16 years (male)**

Bone age per radiological report: _____ Date of last bone age test: _____

2. Epiphyses are: ☐Open ☐Closed

Please complete form, including required attachments and fax to
Drug Prior Authorization Unit at 1-800-294-1350.

1/2020