



Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
 P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Growth Hormone and Increlex Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist.

Member information

Last name _____ First name _____ MI _____
 MassHealth member ID # _____ Date of birth _____
 Gender (Check one.) F M Member's place of residence home nursing facility

Medication information

Medication requested (check one)

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Genotropin | <input type="checkbox"/> Norditropin Flexpro | <input type="checkbox"/> Omnitrope | <input type="checkbox"/> Serostim |
| <input type="checkbox"/> Genotropin Miniquick | <input type="checkbox"/> Nutropin AQ | <input type="checkbox"/> Saizen | <input type="checkbox"/> Zomacton |
| <input type="checkbox"/> Humatrope | <input type="checkbox"/> Nutropin AQ Nuspin | <input type="checkbox"/> Saizen Click.easy | <input type="checkbox"/> Zorbtive |
| <input type="checkbox"/> Increlex | | | |

Dose and frequency of medication requested _____

Duration of therapy _____
 Cartridge/vial strength _____

Indication for Growth Hormone agent (Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Growth hormone deficiency (Section I or III) | <input type="checkbox"/> Prader Willi syndrome (provide documentation of genetic testing) (Section I) |
| <input type="checkbox"/> Growth deficiency due to chronic renal failure (Section I & II) | <input type="checkbox"/> Small for gestational age with failed catch-up growth between age two to four (Section I) |
| <input type="checkbox"/> Hypoglycemia due to growth hormone deficiency (Section I) | <input type="checkbox"/> Turner syndrome (provide documentation of genetic testing) (Section I) |
| <input type="checkbox"/> Human Immunodeficiency Virus-related wasting (Section IV) | <input type="checkbox"/> Other (Section VI or any section that may apply) _____ |
| <input type="checkbox"/> Noonan syndrome (provide documentation of genetic testing) (Section I) | |

Indication for Increlex (Check all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> Growth failure with severe primary IGF-1 deficiency | <input type="checkbox"/> Other (Section VI or any section that may apply) _____ |
| <input type="checkbox"/> Growth hormone gene deletion with neutralizing antibodies to growth hormone | |

Section I. Please complete for growth hormone for pediatric indications and attach supporting documentation (e.g., copies of medical records, office notes, growth charts, diagnostic studies, laboratory tests).

Pre-treatment height ____ cm ____ percentile ____ SD below mean. Please attach most recent growth chart.
Current height ____ Current weight ____ Date ____ Growth rate in past year ____ cm

Please provide information regarding diagnostic tests and assessments including type of growth hormone stimulation test performed, date, and results.

Stimulation Test _____ Peak Result _____ Date _____

Stimulation Test _____ Peak Result _____ Date _____

IGF-1 level _____ Reference Range _____ Date _____

IGFBP-3 level _____ Reference Range _____ Date _____

1. Is patient under the care of a Pediatric Endocrinologist? Yes No

If no, have other causes of short stature (hypothyroidism, malnutrition, chronic illness, skeletal disorders, pituitary tumor) been excluded? Yes No

2. Does patient have open epiphyses? Yes (Please attach most recent bone age, if available.) No (Please attach clinical rationale for continued treatment and/or refer to Section III.)

3. Has pituitary imaging revealed abnormalities?

Yes Please attach medical records documenting abnormality. No

4. Does the member have hypoglycemia-symptoms and low glucose level?

Yes. Please provide glucose level _____ Date _____ No

Section II. Please complete for growth hormone requests for the diagnosis of pediatric-growth deficiency due to chronic renal failure.

1. Have other etiologies for chronic renal failure been excluded including: acidosis, secondary hyperparathyroidism, malnutrition, or zinc deficiency? Yes No

2. Is the member under the care of a renal specialist? Yes No

Section III. Please complete for growth hormone requests for growth hormone deficiency in adult members.

Please provide information regarding diagnostic tests and assessments including type of growth hormone stimulation test performed, date, and results.

Stimulation Test _____ Peak Result _____ Date _____

Stimulation Test _____ Peak Result _____ Date _____

IGF-1 level _____ Reference Range _____ Date _____

IGFBP-3 level _____ Reference Range _____ Date _____

1. Has pituitary imaging revealed abnormalities?

Yes (Please attach medical records documenting abnormality.) No

2. Has the member experienced a complication due to growth hormone deficiency? Yes No

If yes, please describe. _____

Section IV. Please complete for growth hormone requests for HIV-related wasting.

Current height ____ Current weight ____ Date ____ Premorbid weight ____ Date _____

1. Is decreased caloric intake the etiology of the cachexia or wasting? Yes No

If yes, has member attempted therapy with dronabinol or megestrol acetate? If so, provide dates and duration. If not, please explain why.

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____