NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF PAYMENT
GROWTH HORMONE (GH) FOR CHILDREN

Please go to NebraskaTotalCare.com for preferred drug list and criteria regarding prior authorizations

(Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.)

PRESCRIBING PROVIDER: _____ **MEDICAID RECIPIENT:** _____

Name: _____ Name: _____
(First, Last) (First, Last)

Phone #: (_____)- _____

Medicaid #: _____

Fax #: (____)- _____ Date of Birth: _____/_____/_____

Physician Specialty _____ Other Insurance Information /

ID#:_____

NPI # _____ (NOTE: Patient must be 18 years or younger.)

PARTICIPATING PHARMACY:

Name: _____ Phone #: (____) _____ Fax #: (____) _____

DRUG/CLINICAL INFORMATION: **Request Date:** _____

□ **Initial Primary Diagnosis:** _____

□ **Growth hormone deficiency (GHD) associated with chronic kidney disease (CKD),** pre-transplant GFR < 75mL/min: GFR _____ mL/min (CRF only); Dialysis: Y / N; Transplant: Y / N.

□ **Documented GH deficiency (GHD) including pituitary dwarfism.**

□ **Other** (specify) _____

Provocative testing: (Initial GHD Only)

Agent 1 _____ Peak _____ Date _____

Agent 2 _____ Peak _____ Date _____

□ **Prader-Willi Syndrome (PWS)** diagnostic test: Diagnostic results _____ Attach copy of original study.

□ **Noonan Syndrome** Attach copy of chart notes or testing.

☐ **SHOX Deficiency** diagnosed by documentation of SHOX gene: SHOX test Results _____ Attach copy of original study.

☐ **Turner's Syndrome (TS)** diagnostic test: Diagnostic results _____ Attach copy of original study.

Date of Most Recent Clinic Visit_____

Diagnostic testing (attach all results):

Physical Stature Percentile_____ ; Height_____cm; Weight _____kg; Tanner Stage_____ .

Bone Age _____Yr _____Mo; Chronological Age _____Yr _____Mo; Date of Scan _____ .

Mother's Height_____ cm; Father's Height_____ cm.

Growth Velocity _____cm/yr

Epiphyses Open: Yes or No (Circle one)

All causes for short stature, other than GH deficiency, ruled out? Yes or No (Circle one)

IGF-1 level & reference range **OR** IGFBP3 level & reference range_____

Thyroid level & reference range _____ Morning Cortisol level & reference range _____

What, if any, hormone replacement therapy, is client receiving:_____

☐**Dose Change**; Current weight: _____

For Renewal of Therapy:

Please provide the annual height velocity growth (in centimeters/year) achieved during the previous therapy._____ cm/yr

Please provide the percentage change of growth velocity from baseline. _____ %

☐Yes ☐No Has final adult height been reached?

☐Yes ☐No Have there been any persistent and uncorrectable problems with adherence to treatment?

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. I also attest that I have obtained authorization to release the above information. I will be supervising the patient's treatment.

Prescriber Signature: _____ Date: _____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)

Please note: The Department may request chart documentation to verify the above information.

Submit request to: Pharmacy Services Fax: 833-404-2254, Tel: 844-330-7852

Submit prior authorization (PA) requests electronically through our preferred solution **CoverMyMeds** at CoverMyMeds.com/main/prior-authorization-forms/.

Revised 04/2022