



**Growth Hormone
Prior Authorization Form**

**Fax completed form to:
855-207-0250
For questions regarding this
prior authorization, call
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving preferred growth hormone meet one of the criteria below (member's receiving a non-preferred growth hormone product must be switched to a preferred agent):

- Multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease or its treatment (brain surgery and/or radiation)
- Turner's syndrome
- SHOX syndrome
- Noonan syndrome
- Chronic renal insufficiency
- Prader-Willi syndrome
- See growth hormone criteria for additional information – www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Drug and Dosage:		Diagnosis for this request:

Qualifications for coverage:

Does the member have any active malignancy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the member attained epiphyseal closure?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the member consult with a dietician to maintain a nutritious diet?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Is growth hormone needed to maintain proper blood glucose (<i>endogenous GH deficiency only</i>)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the member have multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary Disease (<i>endogenous GH deficiency only</i>)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the member received a renal transplant (<i>chronic renal insufficiency only</i>)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has a diagnosis of sleep apnea been ruled out in this member (<i>Prader-Willi syndrome only</i>)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are all lab values stated as required in the criteria attached to this request?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Member's current BMI (Prader-Willi syndrome only):

Prescriber (or Staff) / Pharmacy Signature**	Date
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***:* By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #