health information designs

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 patients receiving preferred growth hormone meet one of the criteria below (patient'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/2017/Criteria/growth_hormone_criteria.pdf

Part I: TO BE COMPLETED BY PRESCRIBER

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		

Qualifications for coverage:

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

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

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *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 patient'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 #