Acentra HEALTH

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 growth hormone to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Specialist involved in therapy *(only applicable if criteria requires)*		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Directions:	**Strength:**	**Dosage Form (e.g., tablet):**	

Diagnosis for this request:

Qualifications for coverage:

1. Does the member have any active malignancy? ☐ YES ☐NO
2. Has the member attained epiphyseal closure? ☐ YES ☐NO

Please complete the following sections for the listed diagnosis for the request:

PART A: Endogenous growth hormone deficiency:

1. Is growth hormone needed to maintain proper blood glucose? ☐ YES ☐NO
2. Does the member have multiple pituitary hormone deficiencies caused by a known hypothalamic-pituitary disease? ☐ YES ☐NO
3. **Documentation required for <u>INITIAL</u> requests only:** Please confirm the following is attached to the request
   - ☐ IFG-1 or IGFBP-3 level
   - ☐ GH stimulation testing by at least two different stimuli (e.g., insulin, levodopa, Larginine, propranolol, clonidine, or glucagon), no more than 6 months apart

PART B: Chronic renal insufficiency:

1. Has the member received a renal transplant? ☐ YES ☐NO
2. Does the member consult with a dietician annually to maintain a nutritious diet? ☐ YES ☐NO

PART C: Prader-Willi syndrome:

1. Member's current BMI: _____ - if the member's BMI is ≥ 95th percentile and < 120% of the 95th percentile for age and gender, please answer all of the following:
   a. Does the member consult with a dietician every 3 months to maintain a nutritious diet? ☐ YES ☐NO
   b. Has a diagnosis of sleep apnea been ruled out in this member by a sleep study? ☐ YES ☐NO
   c. Does the member have non-alcoholic fatty liver disease? ☐ YES ☐NO
   d. Member's current A1c: _____

Clinical justification explaining why the member is unable to use the preferred agents (only applicable if criteria requires):

Renewal Requests only: assessment of the member's clinical benefit since starting the requested agent

Prader-Willi Syndrome: member's current BMI: _____- if the member's BMI is ≥ 95th percentile and < 120% of the 95th percentile for age and gender, please answer the following:

1. Has the member met with a dietician at least 2 times in the past 6 months? ☐ YES ☐NO

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the member.*

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 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.*