Reset Form Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Growth Hormone Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. Is the prescriber an endocrinologist or nephrologist, or has one been consulted on this case? ☐ Yes ☐ No
2. Has an MRI of the brain been performed? ☐ Yes ☐ No
3. What is the patient's age? _____ What is the patient's height? _____
4. Is patient a newborn with hypoglycemia and a diagnosis of hypopituitarism or panhypopituitarism? ☐ Yes ☐ No

(Form continued on next page.)

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696

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Review Date: 06/03/2026

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

5. What is the diagnosis/condition being treated with this medication? (Check all that apply.)

- ☐ Growth hormone deficiency (pediatric)
- ☐ Growth hormone deficiency (adult onset)
- ☐ Prader-Willi Syndrome
- ☐ Turner Syndrome
- ☐ Renal Insufficiency
- ☐ Chronic Renal Insufficiency
- ☐ Noonan Syndrome
- ☐ HIV wasting or cachexia
- ☐ Small for Gestational Age
- ☐ Short Stature Homeobox gene
- ☐ Idiopathic Short Stature

LAB/TEST RESULTS (Please provide all lab/test results that apply to the condition being treated.)

6. Are the epiphyses open or closed? _____
7. What are the results of bone age studies? _____
8. Is the patient's height more than 2 SD below average for population mean height for age and sex? ☐ Yes ☐ No
9. Is the patient's height velocity measured over one year to be 1 SD below the mean for chronological age? ☐ Yes ☐ No
10. For children over two years of age, has there been a decrease in height SD of more than 0.5 over one year? ☐ Yes ☐ No
11. What is the patient's growth hormone response to a provocative stimulation test? (Two are required: insulin, levodopa, L-Arginine, clonidine, or glucagon) _____ng/mL
12. In adult onset growth hormone deficiency, have the following hormonal deficiencies been ruled out? (Check all that apply.)

- ☐ Thyroid
- ☐ Cortisol
- ☐ Sex Steroids

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

MISCELLANEOUS REQUIRED INFO (Please provide if applicable.)

13. (Ngenla®and Skytrofa®): Has the patient had a trial of a short-acting somatropin product? ☐ Yes ☐ No
    If yes, please list treatment failures and provide dates:

    _____

14. **Serostim only:** If being prescribed for AIDS wasting or cachexia, has the patient had documented failure, intolerance, or contraindication to appetite stimulants and/or other anabolic agents (both Megace and Marinol)? ☐ Yes ☐ No

15. If this is a renewal, has patient had a positive response to therapy? ☐ Yes ☐ No
    Please provide information to support a positive response to therapy (e.g., improvements in height, weight, body composition, increased growth velocity, response on growth curve chart). Please provide quantitative improvements.

    _____

16. Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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