Prior Authorization Request
Nevada Medicaid – Molina Healthcare

Growth Hormone for Recipients Under Age 21

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:		
MEMBER INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Molina ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:	Strength:	
Dosage:	Duration:	

Diagnosis **(REQUIRED)**:

☐ Turner's Syndrome ☐ Prader-Willi Syndrome ☐ Chronic renal insufficiency ☐ Hypothalmic pituitary disease
☐ Small for gestational age ☐ Idiopathic short stature ☐ Other (document): _____

COVERAGE CRITERIA

Please check the applicable boxes to indicate each item as true for the recipient:

This request is for *(check one)*: ☐ Initial therapy ☐ Continuing therapy
The recipient has been evaluated by a: ☐ Pediatric nephrologist ☐ Pediatric endocrinologist
All other causes for short stature have been ruled out. ☐ Yes ☐ No
Epiphyses: ☐ Open ☐ Closed
The recipient has received a renal transplant. ☐ Yes ☐ No
The recipient has deficiencies in three or more pituitary axes (TSH, LH, FSH, ACTH, ADH). ☐ Yes ☐ No
The recipient is receiving adequate replacement therapy for other hormone deficiencies if required. ☐ Yes ☐ No
The recipient has expanding intracranial lesions or tumor formation. ☐ Yes ☐ No
The recipient's bone age is >2 standard deviations below the mean for age. ☐ Yes ☐ No
The recipient's height is >2.25 standard deviations below mean for age. ☐ Yes ☐ No
The recipient's height is >2 standard deviations below the mid-parenteral height percentile. ☐ Yes ☐ No
The recipient's growth velocity is <25th percentile for bone age or normal height for gender. ☐ Yes ☐ No
The recipient's growth rate on treatment is >2 cm compared to the untreated rate (continuing therapy only). ☐ Yes ☐ No
Please provide information regarding any diagnostic tests or assessments performed:

☐ **Growth hormone stimulation test** Date:_____ Level:_____ng/ml
☐ **IGF-1** Date:_____ Level:_____ng/ml
☐ **IGF-BP3** Date:_____ Level:_____ng/ml
☐ **Blood glucose** Date:_____ Level:_____mg/dl

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature:_____ **Date:** _____