MHS PHARMACY BENEFIT
PEDIATRIC (<18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM

MHS
429 N Pennsylvania St. Suite 109
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication and Strength	Dosage	Treatment Duration

SOMATROPIN AGENTS – Initial Authorization

Please select the member's diagnosis:

- ☐ Growth hormone deficiency
- ☐ Noonan syndrome (Norditropin only)
- ☐ Prader-Willi syndrome
- ☐ Renal function impairment associated with growth failure (Nutropin or Nutropin AQ only)
- ☐ Short-stature homeobox-containing gene (SHOX) deficiency (Humatrope or Zomacton only)
- ☐ Small for gestational age (SGA)
- ☐ Turner syndrome
- ☐ Other* (please provide diagnosis)_____
- ☐ N/A

The following documentation will be required for any of the above diagnoses

- ☐ Documentation of biochemical evidence or testing supporting the diagnosis is required
- ☐ Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- ☐ Radiology report documenting open epiphyses (**NOTE:** documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))

Diagnosis of Idiopathic short stature ☐ Yes ☐ No ☐ N/A

The following documentation will be required for any of the above diagnosis

- ☐ Confirmatory growth chart documentation is required illustrating both of the following:
  - Height measurement of more than 2.0 standard deviations below population mean for given age
  - Growth rate of 5 cm/year or less prior to starting growth hormone therapy

Please complete the following:

Current height: _____ (inches)

Height 6 months prior: _____(inches)

Height 12 months prior: _____(inches)

For all indications – Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy ☐ Yes ☐ No

I, _____hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.

Prescriber Signature: _____

INCRELEX (MECASERMIN) – Initial Authorization

Diagnosis of growth failure due to severe primary insulin-like growth factor-1 deficiency (primary IGFD) OR growth hormone (GH) gene deletion with acquired neutralizing antibodies to GH ☐ Yes ☐ No

Member is greater than or equal to 2 years of age and less than 18 years of age ☐ Yes ☐ No

The following documentation will be required for the above diagnosis

- ☐ Radiology report documenting open epiphyses
- ☐ Documentation of baseline height and weight

Please complete the following:

- Baseline height: _____ (inches)
- Baseline weight: _____(kg or lb)

INCRELEX (MECASERMIN) – Reauthorization

Member is less than 18 years of age ☐ Yes ☐ No

Improvement in annualized growth velocity (AGV) OR provider has submitted valid medical rationale for continued use ☐ Yes ☐ No

Please complete the following:

- Current height: _____ (inches)

- Height 6 months prior: _____(inches)
- Height 12 months prior: _____(inches)

The following documentation will be required for the above diagnosis

- ☐ Radiology report documenting open epiphyses

SOMATROPIN AGENTS – Reauthorization

The following documentation will be required for any of the indicated diagnoses

- ☐ Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- ☐ Radiology report documenting open epiphyses (**NOTE:** documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))

The following documentation will be required for the diagnosis of idiopathic short stature only
Growth rate of 2 to 2.5 cm/year or more with growth hormone therapy OR provider has submitted valid medical rationale for continued use

Please complete the following:

- Current height: _____ (inches)
- Height 6 months prior: _____(inches)
- Height 12 months prior: _____(inches)

Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate ☐ Yes ☐ No

I, _____hereby attest that I continue to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: _____

SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Initial Authorization

Diagnosis of growth failure due to growth hormone deficiency ☐ Yes ☐ No

Member is less than 18 years of age AND weighs 11.5 kg or greater ☐ Yes ☐ No

- Weight: _____ (kg or lb)

The following documentation will be required for the above diagnosis

- ☐ Documentation of biochemical evidence or testing supporting the diagnosis is required
- ☐ Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- ☐ Radiology report documenting open epiphyses (**NOTE:** documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))

Trial and failure of all preferred somatropin products ☐ Yes ☐ No

- ☐ If yes, please provide agent trialed, dose and frequency, duration of trial, and reason for failure:
  _____
  _____
  _____
  _____
- ☐ If no, please provide medical rationale as to why the available preferred somatropin agent(s) are unsuitable for use:
  _____
  _____
  _____
  _____

Provider attests that they have performed all necessary testing to ensure there are no expanding intracranial lesions or tumors prior to initiating growth hormone therapy ☐ Yes ☐ No

I, _____hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors that could be negatively impacted by growth hormone therapy.

Prescriber Signature: _____

SKYTROFA (LONAPEGSOMATROPIN-TCGD) – Reauthorization

The following documentation will be required for any of the indicated diagnoses

- ☐ Radiology report documenting a bone age of 14-15 or less in females, 16-17 or less in males
- ☐ Radiology report documenting open epiphyses (**NOTE:** documented evidence of open epiphyses is needed only if member is nearing or at puberty (estimate age range 10-17 years of age))

Member is less than 18 years of age ☐ Yes ☐ No

Provider attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate ☐ Yes ☐ No

I, _____hereby attest that I continue to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate.

Prescriber Signature: _____

VOXZOGO (VOSORITIDE) – Initial Authorization

Diagnosis of achondroplasia ☐ Yes ☐ No

Member is greater than or equal to 5 years of age and less than 18 years of age ☐ Yes ☐ No

The following documentation will be required for the above diagnosis

- ☐ Radiology report documenting open epiphyses
- ☐ Documentation of baseline height and weight

Please complete the following:

- Baseline height: _____ (inches)
- Baseline weight: _____(kg or lb)

VOXZOGO (VOSORITIDE) – Reauthorization

Member is less than 18 years of age ☐ Yes ☐ No

Improvement in annualized growth velocity (AGV) of 1.5 cm/year OR provider has submitted valid medical rationale for continued use ☐ Yes ☐ No

Please complete the following:

- Current height: _____ (inches)
- Height 6 months prior: _____(inches)
- Height 12 months prior: _____(inches)

The following documentation will be required for the above diagnosis

- ☐ Radiology report documenting open epiphyses