TEXAS MEDICAID
Clinical Edit Prior Authorization
Growth Hormones:
GENOTROPIN & NORDITROPIN

Cook Children's Health Plan Only

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

STEP 2: INDICATE PREFERRED PHARMACY

- ☐ Cook Children's Home Health Pharmacy (Phone: 682-303-2230, Fax: 682-885-2499)
- ☐ Maxor Pharmacy (Phone: 866-629-6779, Fax: 866-217-8034)
- ☐ Premier Kids Care Pharmacy (Phone: 888-892-9001, Fax: 866-810-4021)
- ☐ CVS/Pharmacy #2751 – Fort Worth, TX (Phone: 866-566-1548, Fax: 866-320-8853)
- ☐ CVS/Pharmacy #2859 – San Antonio, TX (Phone: 210-616-0080, Fax: 210-614-7859)
- ☐ CVS/Pharmacy #2921 – Monroeville, PA (Phone: 800-238-7828, Fax: 877-287-7226)
- ☐ InTouch Pharmacy (Phone: 877-874-5099, Fax: 706-534-6722)
- ☐ Goodsense Pharmacy (Phone: 210-802-2640; Fax: 210-802-2680)

STEP 3: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD-10 Code: _____

1. Is the client 0 to 16 (greater than (>) 0 and less than or equal to (≤) 16) years of age?

   ☐ Yes (Go to # 2) ☐ No (Go to # 9)

2. Does the client have a diagnosis of growth hormone deficiency (GHD) or idiopathic short stature (ISS) in the last 3 years? ☐ Yes (Go to # 8) ☐ No (Go to # 3)
3. Does the client have a diagnosis of panhypopituitarism in the last 3 years? ☐ Yes (Go to # 4) ☐ No (Go to # 5)
4. Has the client had at least 2 claims for the requested medication in the last 90 days (stable therapy)? ☐ Yes (Go to # 13) ☐ No (Go to # 8)
5. Does the client have a diagnosis of ONE (1) of the following in the last 3 years? • Short Stature Homeobox-Containing Gene (SHOX) Deficiency • Turner Syndrome • Noonan Syndrome • Prader-Willi Syndrome ☐ Yes (Go to # 13) ☐ No (Go to # 6)
6. Does the client have a diagnosis of chronic kidney disease (CKD) in the last 3 years? ☐ Yes (Go to # 7) ☐ No (Deny)
7. Does the client have a history of a renal transplant (CPT) in the last 3 years? ☐ Yes (Deny) ☐ No (Go to #8)
8. Does the submitted documentation support the requested diagnosis? [Manual Step - NOTE: For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months]. ☐ Yes (Go to # 13) ☐ No (Deny)
9. Does the client have a diagnosis of panhypopituitarism in the last 3 years? ☐ Yes (Go to # 11) ☐ No (Go to # 10)
10. Does the client have a diagnosis of growth hormone deficiency (GHD) or idiopathic short stature (ISS) in the last 3 years? ☐ Yes (Go to # 12) ☐ No (Deny)

11. Has the client had at least 2 claims for the requested medication in the last 90 days (stable therapy)?

☐ Yes (Go to # 13) ☐ No (Go to # 12)

12. Does the submitted documentation support the requested diagnosis? [Manual Step - NOTE: For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months].

☐ Yes (Go to # 13) ☐ No (Deny)

13. Does the client have a diagnosis of active malignancy in the last 180 days?

☐ Yes (Deny) ☐ No (Go to # 14)

14. Does the client have a history of chemotherapy/radiation (CPTs) in the last 180 days?

☐ Yes (Deny) ☐ No (Go to # 15)

15. Does the client have a diagnosis of active proliferative or severe non-proliferative diabetic retinopathy in the last 365 days?

☐ Yes (Deny) ☐ No (Approve – 365 days)

STEP 4: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.

GROWTH HORMONE QUICK REFERENCE GUIDE

Testing Requirements for Clients ≤ 16 Years of Age

Growth Hormone (Excluding Serostim and Zorbtive) **Growth Hormone Deficiency, Idiopathic Short Stature, Panhypopituitarism, Chronic Kidney Disease, SHOX Deficiency, Turner Syndrome, Noonan Syndrome and Prader-Willi Syndrome in Children**	
Diagnosis	**Testing Requirements:** For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months
Panhypopituitarism	Initiation of GH Therapy: • IGF-1 level < 160 ng/mL, **AND** • Failure to respond (response ≤ 5 ng/mL) to one growth hormone stimulation test (Note: children < 12 months of age are excluded from provocative testing) Renewal of GH Therapy: • No additional testing is required
Growth Hormone Deficiency (GHD)	Initiation of GH Therapy: • Failure to respond (response < 10 ng/mL) to at least 2 growth hormone stimulation tests (Note: children < 12 months of age are excluded from provocative testing), **AND** • Patient's height > 2.25 SD below the mean for age **OR** patient's height > 2 SD below the midparental height percentile, **AND** • Growth velocity < 25th percentile for bone age Renewal of GH Therapy: • Patient's growth should exceed 2 cm/year, **AND** • Epiphyses are open
Idiopathic Short Stature (ISS)	Initiation of GH Therapy: • Height > 2.25 SD below the mean for age, **AND** • Predicted adult height < 63 inches for males and < 59 inches for females Renewal of GH Therapy: • Patient's growth should exceed 2 cm/year, **OR** show an increase in height velocity of 50%, **OR** an increase of at least 2.5 cm/year above the baseline height velocity, **AND** • Epiphyses are open

Chronic Kidney Disease	<u>Initiation of GH Therapy</u>: • GFR ≤ 75mL/min/1.73m^2, **AND** • Patient's height > 2.25 SD below the mean for age **OR** patient's height > 2 SD below the midparental height percentile **OR** patient's Z score < -1.88, **AND** • Pre-transplant <u>Renewal of GH Therapy</u>: • Patient's growth should exceed 2 cm/year, **AND** • Pre-transplant, **AND** • Epiphyses are open
SHOX Deficiency, Turner Syndrome, Noonan Syndrome and Prader-Willi Syndrome	• Diagnosis only is required, no additional testing is requested

Testing Requirements for Clients > 16 Years of Age

Growth Hormone (Excluding Serostim and Zorbtive) Panhypopituitarism, Growth Hormone Deficiency or Idiopathic Short Stature in patients > 16 years of age	
Diagnosis	**Testing Requirements:** For initial requests, documentation must be from within the past 12 months. For renewal requests, documentation must be from within the past 6 months
Panhypopituitarism	Initiation of GH Therapy: • IGF-1 level < 160 ng/mL, **AND** • Failure to respond to one growth hormone stimulation test (response ≤ 5ng/mL) Renewal of GH Therapy: • No additional testing is required
Idiopathic Short Stature (ISS)	Renewal of GH Therapy: • If patient has been treated as a pediatric patient (≤ 16 years of age) and is requesting a refill, patient's growth should exceed 2 cm/year, **AND** • Bone age < 16 years, **AND** • Epiphyses are open
Growth Hormone Deficiency (GHD) with no other pituitary deficiency	Initiation of GH Therapy: • IGF-1 level < 160 ng/mL, **AND** • Failure to respond to two growth hormone stimulation tests (response ≤ 5ng/mL) Renewal of GH Therapy: • No additional testing is required