



**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 # 13)



**TEXAS MEDICAID**  
**Clinical Edit Prior Authorization**  
**Growth Hormones:**  
**GENOTROPIN & NORDITROPIN**  
**Cook Children's Health Plan Only**

<p>2. Does the client have a diagnosis of growth hormone deficiency (GHD) in the last 3 years?</p> <p><input type="checkbox"/> Yes (Go to # 12) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 3)</span></p>
<p>3. Does the client have a diagnosis of panhypopituitarism in the last 3 years?</p> <p><input type="checkbox"/> Yes (Go to # 4) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 5)</span></p>
<p>4. Has the client had at least 2 claims for the requested medication in the last 90 days (stable therapy)?</p> <p><input type="checkbox"/> Yes (Go to # 17) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 12)</span></p>
<p>5. Does the client have a diagnosis of idiopathic short stature (ISS) in the last 3 years?</p> <p><input type="checkbox"/> Yes (Go to # 12) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 6)</span></p>
<p>6. Does the client have a diagnosis of ONE (1) of the following in the last 3 years?</p> <ul style="list-style-type: none"><li>• Short Stature Homeobox-Containing Gene (SHOX) Deficiency</li><li>• Turner Syndrome</li><li>• Noonan Syndrome</li></ul> <p><input type="checkbox"/> Yes (Go to # 17) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 7)</span></p>
<p>7. Does the client have a diagnosis of Prader-Willi syndrome in the last 3 years?</p> <p><input type="checkbox"/> Yes (Go to # 8) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 10)</span></p>
<p>8. Does the client have a diagnosis of obstructive sleep apnea in the last 365 days?</p> <p><input type="checkbox"/> Yes (Go to # 9) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 17)</span></p>
<p>9. Does the client have a history of continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP) in the last 730 days?</p> <p><input type="checkbox"/> Yes (Go to # 17) <span style="margin-left: 200px;"><input type="checkbox"/> No (Deny)</span></p>
<p>10. Does the client have a diagnosis of chronic kidney disease (CKD) in the last 3 years?</p> <p><input type="checkbox"/> Yes (Go to # 11) <span style="margin-left: 200px;"><input type="checkbox"/> No (Deny)</span></p>
<p>11. Does the client have a history of a renal transplant (CPT) in the last 3 years?</p> <p><input type="checkbox"/> Yes (Deny) <span style="margin-left: 200px;"><input type="checkbox"/> No (Go to # 12)</span></p>



**TEXAS MEDICAID**  
**Clinical Edit Prior Authorization**  
**Growth Hormones:**  
**GENOTROPIN & NORDITROPIN**  
**Cook Children's Health Plan Only**

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 # 17)  No (Deny)

13. Does the client have a diagnosis of panhypopituitarism in the last 3 years?

Yes (Go to # 15)  No (Go to # 14)

14. Does the client have a diagnosis of growth hormone deficiency (GHD) or idiopathic short stature (ISS) in the last 3 years?

Yes (Go to # 16)  No (Deny)

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

Yes (Go to # 17)  No (Go to # 16)

16. 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 # 17)  No (Deny)

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

Yes (Deny)  No (Go to # 18)

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

Yes (Deny)  No (Go to # 19)

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

Yes (Deny)  No (Go to # 20)

20. Does the client have a diagnosis of papilledema in the last 180 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.



**TEXAS MEDICAID**  
**Clinical Edit Prior Authorization**  
**Growth Hormones:**  
**GENOTROPIN & NORDITROPIN**  
**Cook Children’s Health Plan Only**

**GROWTH HORMONE QUICK REFERENCE GUIDE**

**Testing Requirements for Clients ≤ 16 Years of Age**

<b>Growth Hormone (Excluding Serostim and Zorbtive)</b> <b>Growth Hormone Deficiency, Idiopathic Short Stature, Panhypopituitarism, Chronic Kidney Disease, SHOX Deficiency, Turner Syndrome, Noonan Syndrome and Prader-Willi Syndrome in Children</b>	
<b>Diagnosis</b>	<b>Testing Requirements:</b> 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	<p><u>Initiation of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• IGF-1 level &lt; 160 ng/mL, <b>AND</b></li> <li>• Failure to respond (response ≤ 5 ng/mL) to one growth hormone stimulation test (Note: children &lt; 12 months of age are excluded from provocative testing)</li> </ul> <p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• No additional testing is required</li> </ul>
Growth Hormone Deficiency (GHD)	<p><u>Initiation of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• Failure to respond (response &lt; 10 ng/mL) to at least 2 growth hormone stimulation tests (Note: children &lt; 12 months of age are excluded from provocative testing), <b>AND</b></li> <li>• Patient’s height &gt; 2.25 SD below the mean for age <b>OR</b> patient’s height &gt; 2 SD below the midparental height percentile, <b>AND</b></li> <li>• Growth velocity &lt; 25th percentile for bone age</li> </ul> <p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• Patient’s growth should exceed 2 cm/year, <b>AND</b></li> <li>• Epiphyses are open</li> </ul>
Idiopathic Short Stature (ISS)	<p><u>Initiation of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• Height &gt; 2.25 SD below the mean for age, <b>AND</b></li> <li>• Predicted adult height &lt; 63 inches for males and &lt; 59 inches for females</li> </ul> <p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• Patient’s growth should exceed 2 cm/year, <b>OR</b> show an increase in height velocity of 50%, <b>OR</b> an increase of at least 2.5 cm/year above the baseline height velocity, <b>AND</b></li> <li>• Epiphyses are open</li> </ul>



**TEXAS MEDICAID  
Clinical Edit Prior Authorization  
Growth Hormones:  
GENOTROPIN & NORDITROPIN  
Cook Children's Health Plan Only**

<p style="text-align: center;">Chronic Kidney Disease</p>	<p><u>Initiation of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• GFR <math>\leq</math> 75mL/min/1.73m<sup>2</sup>, <b>AND</b></li> <li>• Patient's height &gt; 2.25 SD below the mean for age <b>OR</b> patient's height &gt; 2 SD below the midparental height percentile <b>OR</b> patient's Z score &lt; -1.88, <b>AND</b></li> <li>• Pre-transplant</li> </ul> <p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• Patient's growth should exceed 2 cm/year, <b>AND</b></li> <li>• Pre-transplant, <b>AND</b></li> <li>• Epiphyses are open</li> </ul>
<p>SHOX Deficiency, Turner Syndrome, Noonan Syndrome and Prader-Willi Syndrome</p>	<ul style="list-style-type: none"> <li>• Diagnosis only is required, no additional testing is requested</li> </ul>



**TEXAS MEDICAID  
Clinical Edit Prior Authorization  
Growth Hormones:  
GENOTROPIN & NORDITROPIN  
Cook Children's Health Plan Only**

**Testing Requirements for Clients > 16 Years of Age**

<b>Growth Hormone (Excluding Serostim and Zorbtive) Panhypopituitarism, Growth Hormone Deficiency or Idiopathic Short Stature in patients &gt; 16 years of age</b>	
<b>Diagnosis</b>	<b>Testing Requirements:</b> 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	<p><u>Initiation of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• IGF-1 level &lt; 160 ng/mL, <b>AND</b></li> <li>• Failure to respond to one growth hormone stimulation test (response ≤ 5ng/mL)</li> </ul> <p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• No additional testing is required</li> </ul>
Idiopathic Short Stature (ISS)	<p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• 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, <b>AND</b></li> <li>• Bone age &lt; 16 years, <b>AND</b></li> <li>• Epiphyses are open</li> </ul>
Growth Hormone Deficiency (GHD) with no other pituitary deficiency	<p><u>Initiation of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• IGF-1 level &lt; 160 ng/mL, <b>AND</b></li> <li>• Failure to respond to two growth hormone stimulation tests (response ≤ 5ng/mL)</li> </ul> <p><u>Renewal of GH Therapy:</u></p> <ul style="list-style-type: none"> <li>• No additional testing is required</li> </ul>