MISSISSIPPI DIVISION OF MEDICAID

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit, PO Box 2480, Ridgeland, MS 39158

☐ **Medicaid Fee for Service**/Gainwell Technologies
Fax to: 1-866-644-6147 Ph: 1-833-660-2402
https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

☐ **Magnolia Health**/Envolve Pharmacy Solutions
Fax to: 1-877-386-4695 Ph: 1-866-399-0928
https://www.magnoliahealthplan.com/providers/pharmacy.html

☐ **UnitedHealthcare**/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html

☐ **Molina Healthcare**/CVS Caremark
Fax to: 1-844-312-6371 Ph: 1-844-826-4335
http://www.molinahealthcare.com/providers/ms/medicaid/pages/home.aspx

BENEFICIARY INFORMATION	
Beneficiary ID---------- _____	**DOB:**_____ /_____ /_____
Beneficiary Full Name:	
PRESCRIBER INFORMATION	
Prescriber's NPI:	
Prescriber's Full Name:	**Phone:**
Prescriber's Address:	**FAX:**
PHARMACY INFORMATION	
Pharmacy NPI:	
Pharmacy Name:	
Pharmacy Phone:	**Pharmacy FAX:**

CLINICAL INFORMATION

Requested PA Start Date:_____ **Requested PA End Date:**_____

Drug/Product Requested:_____ **Strength:**_____ **Quantity:**_____

Days Supply:_____ **RX Refills:**_____ **Diagnosis or ICD-10 Code(s):**_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification

PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ **Date:** _____

Printed name of prescribing provider:_____

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SUBMISSION AND/OR APPROVAL OF A DRUG PRIOR AUTHORIZATION REQUEST DOES NOT GUARANTEE MEDICAID PAYMENT FOR PHARMACY PRODUCTS OR THE AMOUNT OF PAYMENT. ELIGIBILITY FOR AND PAYMENT OF MEDICAID SERVICES ARE SUBJECT TO ALL TERMS AND CONDITIONS AND LIMITATIONS OF THE MEDICAID PROGRAM.

10/1/2022

Prior Authorization Criteria

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Recombinant Human Growth Hormone Prior Authorization Criteria

Recombinant human growth hormone (somatropin) is a protein designed to mimic naturally occurring growth hormone. Somatropin promotes tissue and linear growth along with stimulating the metabolism of carbohydrates, lipids, and minerals. Somatropin is a subcutaneous injection routinely administered daily and is used to treat short stature due to growth hormone deficiency, Turner syndrome, Noonan syndrome, Prader-Willi syndrome, short stature homeobox-containing gene (SHOX) deficiency, chronic renal insufficiency, idiopathic short stature, and children small for gestational age.

Diagnosis: _____ ICD-10 code(s): _____

Initial authorization: 12 months

ADULTS

Patient age is 18 years or older
AND
Prescriber is, or has consulted with an endocrinologist or nephrologist
AND
Documented diagnosis of one or more of the following:

- Craniopharyngioma
- Panhypopituitarism
- Prader-Willi Syndrome
- Turner Syndrome
- Other approvable indication

OR
Documented procedure of cranial irradiation

CHILDREN

Patient age is 17 years or younger
AND
Prescriber is, or has consulted with a pediatric endocrinologist or pediatric nephrologist (renal disease)
AND
Documented diagnosis of one or more of the following:

- Iatrogenic growth hormone deficiency
- Small for gestational age
- Growth failure associated with renal insufficiency or chronic kidney disease
- Turner syndrome
- Prader-Willi syndrome
- Noonan syndrome
- Short stature homeobox (SHOX) gene deficiency
- Blind loop syndrome
- Short bowel syndrome
- HIV-associated cachexia (or wasting)

OR

Diagnosis of growth hormone deficiency, as confirmed by the following:

1. Patient's height is more than 2.0 SD below average for the population mean height for age and sex and height velocity measured over 1 year to be 1.0 SD below the mean for chronological age or for children over 2 years of age, a decrease in height SD of more than 0.5 over 1 year [1]
   AND
2. Other causes of poor growth have been ruled out, including hypothyroidism, chronic illness, malnutrition, malabsorption, and genetic syndrome
   AND
3. Growth hormone response of less than 10 ng/ml to at least two provocative stimuli of growth hormone release (clonidine, glucagon, insulin, levodopa, L-Arginine, GNRH, etc.)
   OR

Idiopathic short stature (All above causes have been ruled out):

1. Height more than 2.25 SD below average for the population mean height for age and sex [1]
   OR
2. Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is > 1.5 SD below mid-parental height utilizing age and gender growth charts related to height [2]
   OR
3. A decrease in height SD of more than 0.5 over one year in children over 2 years of age [1]
   OR
4. Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years [1]

Reauthorization: 12 months
Adults (age 18 years or older):

Patient continues to meet criteria for initial approval

Children (age 17 years or younger):

1. Patient continues to meet criteria for initial approval
   AND
2. Prescriber must provide documentation of:
   - Improvement of height deficit relative to mean for age
     OR
   - Improvement of height velocity relative to mean

1. Based on Set 1: Clinical charts with 5th and 95th percentiles. Length/Stature-for-age percentiles. Developed by the National Center for Health Statistics in collaboration with the National Center for Chronic Disease Prevention and Health Promotion http://www.cdc.gov/growthcharts

2. Midparental height formulas
   Boys: [father's height in cm + (mother's height in cm +13 cm)]/2
   Girls: [(father's height in cm – 13 cm) + mother's height in cm]/2
   NOTE: *For midparental height calculation in inches, 1 in = 2.5 cm.*

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HUMAN GROWTH HORMONE

CRITERIA/ ADDITIONAL INFORMATION

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BENEFICIARY INFORMATION

Beneficiary ID---------- _____ **DOB:**_____ /_____ /_____

Beneficiary Full Name:

Adults (18 years and older)

Prescriber is or has consulted with an endocrinologist or appropriate specialist. Requires consult within the past year with documentation of recommended regimen.

Please select diagnosis (Documentation required):

- ◯ Craniopharyngioma
- ◯ Panhypopituitarism
- ◯ Prader-Willi Syndrome
- ◯ Turner Syndrome
- ◯ Other approvable indication: _____
- ◯ Procedure of cranial irradiation

Children (17 years and younger)

Prescriber is or has consulted with a pediatric endocrinologist or pediatric nephrologist (renal disease). Requires consult within the past year with documentation of recommended regimen.

Please select diagnosis (Documentation required):

- ◯ Iatrogenic growth hormone deficiency
- ◯ Noonan syndrome
- ◯ Small for gestational age
- ◯ Short stature homeobox (SHOX) gene
- ◯ Growth failure associated with renal insufficiency or chronic kidney disease
- ◯ Blind loop syndrome
- ◯ Turner syndrome
- ◯ Short bowel syndrome
- ◯ Prader-Willi syndrome
- ◯ HIV-associated cachexia (or wasting)
- ◯ Growth hormone deficiency* (see additional requirements below)
- ◯ Idiopathic short stature** (see additional requirements below)

***Growth hormone deficiency - Provide documentation of:**

- ◯ Patient's height is more than 2.0 SD below average for the population mean height for age and sex and height velocity measured over 1 year to be 1.0 SD below the mean for chronological age or for children over 2 years of age, a decrease in height SD of more than 0.5 over 1 year

AND

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◯ Other causes of poor growth have been ruled out, including hypothyroidism, chronic illness, malnutrition, malabsorption, and genetic syndrome

AND

◯ Growth hormone response of less than 10 ng/ml to at least two provocative stimuli of growth hormone release (clonidine, glucagon, insulin, levodopa, L-Arginine, GNRH, etc.)

****Idiopathic short stature – Provide documentation of:**

◯ Height more than 2.25 SD below average for the population mean height for age and sex

OR

◯ Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is > 1.5 SD below mid-parental height utilizing age and gender growth charts related to height

◯ **OR**

◯ A decrease in height SD of more than 0.5 over one year in children over 2 years of age

OR

◯ Height velocity more than 2 SD below the mean over one year or more than 1.5 SD sustained over 2 years

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