



STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

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

Medicaid Fee for Service/MSCAN/MSCHIP Members
Gainwell Technologies

Fax to: 1-866-644-6147 Ph: 1-833-660-2402
[Pharmacy Prior Authorization - Mississippi Division of Medicaid \(ms.gov\)](http://Pharmacy Prior Authorization - Mississippi Division of Medicaid (ms.gov))

Submit your PA requests via the MESA (Medicaid Enterprise System Assistance) provider portal for the most efficient processing
[Mississippi Medical Assistance Portal for Providers > Home \(ms-medicaid-mesa.com\)](http://Mississippi Medical Assistance Portal for Providers > Home (ms-medicaid-mesa.com))

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): _____	
<input type="checkbox"/> Hospital Discharge <input type="checkbox"/> 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	
<i>Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)</i>	
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.
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7/1/2024



Prior Authorization Criteria

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 | ○ Noonan syndrome |
| ○ Small for gestational age | ○ Short stature homeobox (SHOX) gene deficiency |
| ○ 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) |

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: $[\text{father's height in cm} + (\text{mother's height in cm} + 13 \text{ cm})]/2$
Girls: $[(\text{father's height in cm} - 13 \text{ cm}) + \text{mother's height in cm}]/2$
NOTE: For midparental height calculation in inches, 1 in = 2.5 cm.

**HUMAN GROWTH HORMONE
CRITERIA/ ADDITIONAL INFORMATION**



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):	
<input type="radio"/> Craniopharyngioma	
<input type="radio"/> Panhypopituitarism	
<input type="radio"/> Prader-Willi Syndrome	
<input type="radio"/> Turner Syndrome	
<input type="radio"/> Other approvable indication: _____	
<input type="radio"/> 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):	
<input type="radio"/> Iatrogenic growth hormone deficiency	
<input type="radio"/> Noonan syndrome	
<input type="radio"/> Small for gestational age	
<input type="radio"/> Short stature homeobox (SHOX) gene	
<input type="radio"/> Growth failure associated with renal insufficiency or chronic kidney disease	
<input type="radio"/> Blind loop syndrome	
<input type="radio"/> Turner syndrome	
<input type="radio"/> Short bowel syndrome	
<input type="radio"/> Prader-Willi syndrome	
<input type="radio"/> HIV-associated cachexia (or wasting)	
<input type="radio"/> Growth hormone deficiency* (see additional requirements below)	
<input type="radio"/> Idiopathic short stature** (see additional requirements below)	
*Growth hormone deficiency - Provide documentation of:	
<input type="radio"/> 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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