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Prime THERAPEUTICS™

NYRx the Medicaid Pharmacy Program

Growth Hormones Prior Authorization Worksheet

Fax Number: 800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. Preferred drugs will not require PA if the required coverage parameters, outlined in the PDL, are found in the member's Medicaid claim history at the time of pharmacy claim submission. Nonpreferred drugs will require PA. https://newyork.fhsc.com/

ENROLLEE INFORMATION

Enrollee's Last Name: _____

Enrollee's First Name: _____

Date of Birth: _____

Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter): _____

PRESCRIBER INFORMATION

Prescriber's Last Name: _____

Prescriber's First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber's Street Address: _____

City: _____

State: _____

Zip Code _____

Prescriber's Phone Number: _____

Prescriber's Fax Number: _____

REQUESTED DRUG INFORMATION

Drug Name: _____ **Drug Strength:** _____

Quantity: _____ **Refills:** _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **No**, date therapy was initiated: _____

Revision Date: 08/01/2024

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA

Please answer questions 1 through 4 if requesting a non-preferred growth hormone (a listing of preferred and non-preferred drugs can be found at https://newyork.fhsc.com/). **If requesting a preferred growth hormone, please continue to question 5**.

1. Has the patient has experienced a treatment failure with a preferred growth hormone?
   ☐ Yes ☐ No
2. Has the patient has experienced an adverse drug reaction with a preferred growth hormone?
   ☐ Yes ☐ No
3. Does the patient have a documented history of successful therapeutic control with a non-preferred growth hormone and transition to a preferred growth hormone is medically contraindicated?
   ☐ Yes ☐ No
4. Other – What is the clinical reason the patient is unable to use a preferred growth hormone?

5. What is the diagnosis documented in the patient's chart that requires treatment with growth hormone?
   ☐ Pediatric Growth Hormone Deficiency
   ☐ Prader-Willi Syndrome
   ☐ Noonan Syndrome
   ☐ Chronic Renal Insufficiency
   ☐ Adult with child-onset growth hormone deficiency
   ☐ Idiopathic Short Stature*
   ☐ Small for Gestational Age
   ☐ Turner Syndrome
   ☐ Short Stature Homeobox Gene
   ☐ Hypopituitarism
   ☐ Adult-onset growth hormone deficiency
   ☐ Other

   Provide the clinical rationale for requesting growth hormone for a diagnosis that is not FDA-approved (**Note**: Documentation of the original diagnosis **must** be included with this fax form; *Idiopathic Short Stature is a Medicaid excluded diagnosis https://www.health.ny.gov/health_care/medicaid/program/update/2012/2012-04.htm#short):

For Diagnoses of Pediatric Growth Hormone Deficiency or Small for Gestational Age:

6. Does the prescriber attest to the patient having completed the recommended GHD diagnostic or lab test confirming GHD (required prior to initiating therapy and annually for continuation of therapy)?
   ☐ Yes ☐ No

   If **No**, please resubmit request after the recommended GHD diagnostic or lab test confirming GHD is completed.

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA (*CONTINUED*)

7. For **renewal requests**: Has the patient's growth rate doubled **or** increased by at least ≥ 2 cm in height over the past year of growth hormone therapy?

   ☐ Yes ☐ No

   If **No**, provide rationale for continued therapy despite having suboptimal response to the requested growth hormone therapy.

For Diagnosis of Hypopituitarism in Adults 18 Years of Age and Older:

8. Does the patient have multiple pituitary hormone deficiencies secondary to organic disease, surgery, radiation therapy, or trauma?

   ☐ Yes ☐ No

   Please explain and include chart documentation:

For All Ages:

9. Does the patient have any of the following contraindications (**check all that apply**)?

   ☐ Acute critical illness ☐ Obesity with upper airway obstruction

   ☐ Active malignancy ☐ Sleep apnea or severe respiratory impairment

   ☐ Diabetic retinopathy ☐ None of the above

   If **Yes** to any of the above, provide clinical rationale for requesting the use of growth hormone despite the patient having a contraindication:

Please note that SEC. 303. [21 USC §333] of the Federal Food, Drug, and Cosmetic act states that:

(1) Whoever knowingly distributes, or possesses with intent to distribute, human growth hormone for any use in humans other than the treatment of a disease or other recognized medical condition, where such use has been authorized by the Secretary of Health and Human Services under section 355 and pursuant to the order of a physician, is guilty of an offense punishable by not more than 5 years in prison, such fines as are authorized by title 18, or both.

(2) Whoever commits any offense set forth in paragraph (1) and such offense involves an individual under 18 years of age is punishable by not more than 10 years imprisonment, such fines as are authorized by title 18, or both.

(3) Any conviction for a violation of paragraphs (1) and (2) of this subsection shall be considered a felony violation of the Controlled Substances Act [21 U.S.C. 801 et seq.] for the purposes of forfeiture under section 413 of such Act [21 U.S.C. 853].

(4) As used in this subsection the term "human growth hormone" means somatrem, somatropin, or an analogue of either of them.

(5) The Drug Enforcement Administration is authorized to investigate offenses punishable by this subsection.

Enrollee's Last Name: **Enrollee's First Name:**

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax Number: 800-268-2990
Prior Authorization Call Line: 877-309-9493
Billing Questions: 800-343-9000

For clinical questions or Preferred Drug Program questions, please visit http://newyork.fhsc.com or call 877-309-9493.