



**NYRx the Medicaid Pharmacy Program**

**Growth Hormone – Adult (18 Years and Older)**

**Prior Authorization Worksheet**

**Fax Number: 1-800-268-2990**

Processing may be delayed if information submitted is illegible or incomplete. This form must be completed by the prescriber, not their authorized agent.

**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:** \_\_\_\_\_

Enrollee's Last Name:

Enrollee's First Name:

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**CLINICAL CRITERIA**

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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?  
 Adult with child-onset growth hormone deficiency     Adult-onset growth hormone deficiency  
 Short bowel syndrome     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):**

**For Diagnoses of Growth Hormone Deficiency:**

6. Does the patient have a diagnosis of growth hormone deficiency (GHD) with evidence of a subnormal response to a growth hormone stimulation test?  
 Yes     No

Please explain and include chart documentation:

Enrollee's Last Name:

Enrollee's First Name:

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**CLINICAL CRITERIA (CONTINUED)**

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7. 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:

8. 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       Acute respiratory failure       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.

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**Prescriber's Signature (Required)**

**Date**

*I attest that growth hormone is medically necessary for this patient and that all the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.*

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493

**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit <http://newyork.fhsc.com> or call 1-877-309-9493.