



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586, Worcester, MA 01613-2586  
**Fax:** (877) 208-7428      **Phone:** (800) 745-7318

## Growth Hormone and Increlex Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### Member information

Last name \_\_\_\_\_ First name \_\_\_\_\_ MI \_\_\_\_\_  
 MassHealth member ID # \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Gender (Check one.)  F  M      Member's place of residence  home  nursing facility

### Medication information

#### Medication requested (check one)

- |   |  |  |                                   |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Genotropin           | <input type="checkbox"/> Norditropin Flexpro | <input type="checkbox"/> Omnitrope         | <input type="checkbox"/> Serostim |
| <input type="checkbox"/> Genotropin Miniquick | <input type="checkbox"/> Nutropin AQ         | <input type="checkbox"/> Saizen            | <input type="checkbox"/> Zomacton |
| <input type="checkbox"/> Humatrope            | <input type="checkbox"/> Nutropin AQ Nuspin  | <input type="checkbox"/> Saizen Click.easy | <input type="checkbox"/> Zorbtive |
| <input type="checkbox"/> Increlex             |  |  |                                   |

#### Dose and frequency of medication requested \_\_\_\_\_

Duration of therapy \_\_\_\_\_  
 Cartridge/vial strength \_\_\_\_\_

#### Indication for Growth Hormone agent (Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Growth hormone deficiency (Section I or III)                           | <input type="checkbox"/> Prader Willi syndrome (provide documentation of genetic testing) (Section I)              |
| <input type="checkbox"/> Growth deficiency due to chronic renal failure (Section I & II)        | <input type="checkbox"/> Small for gestational age with failed catch-up growth between age two to four (Section I) |
| <input type="checkbox"/> Hypoglycemia due to growth hormone deficiency (Section I)              | <input type="checkbox"/> Turner syndrome (provide documentation of genetic testing) (Section I)                    |
| <input type="checkbox"/> Human Immunodeficiency Virus-related wasting (Section IV)              | <input type="checkbox"/> Other (Section VI or any section that may apply) _____                                    |
| <input type="checkbox"/> Noonan syndrome (provide documentation of genetic testing) (Section I) |  |

#### Indication for Increlex (Check all that apply.)

- |  |   |
|--|---|
| <input type="checkbox"/> Growth failure with severe primary IGF-1 deficiency                         | <input type="checkbox"/> Other (Section VI or any section that may apply) _____ |
| <input type="checkbox"/> Growth hormone gene deletion with neutralizing antibodies to growth hormone |   |

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**Section I. Please complete for growth hormone for pediatric indications and attach supporting documentation (e.g., copies of medical records, office notes, growth charts, diagnostic studies, laboratory tests).**

Pre-treatment height \_\_\_\_\_ cm \_\_\_\_\_ percentile \_\_\_\_\_ SD below mean. Please attach most recent growth chart.

Current height \_\_\_\_\_ Current weight \_\_\_\_\_ Date \_\_\_\_\_ Growth velocity in past year \_\_\_\_\_ cm

Please provide information regarding diagnostic tests and assessments including type of growth hormone stimulation test performed, date, and results.

Stimulation Test \_\_\_\_\_ Peak Result \_\_\_\_\_ Date \_\_\_\_\_

Stimulation Test \_\_\_\_\_ Peak Result \_\_\_\_\_ Date \_\_\_\_\_

IGF-1 level \_\_\_\_\_ Reference Range \_\_\_\_\_ Date \_\_\_\_\_

IGFBP-3 level \_\_\_\_\_ Reference Range \_\_\_\_\_ Date \_\_\_\_\_

1. Is patient under the care of a Pediatric Endocrinologist?  Yes  No

If no, have other causes of short stature (hypothyroidism, malnutrition, chronic illness, skeletal disorders, pituitary tumor) been excluded?  Yes  No

2. Does patient have open epiphyses?  Yes (Please attach most recent bone age, if available.)  No (Please attach clinical rationale for continued treatment and/or refer to Section III.)

3. Has pituitary imaging revealed abnormalities?

Yes Please attach medical records documenting abnormality.  No

4. Does the member have hypoglycemia-symptoms and low glucose level?

Yes. Please provide glucose level \_\_\_\_\_ Date \_\_\_\_\_  No

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**Section II. Please complete for growth hormone requests for the diagnosis of pediatric-growth deficiency due to chronic renal failure.**

1. Have other etiologies for chronic renal failure been excluded including: acidosis, secondary hyperparathyroidism, malnutrition, or zinc deficiency?  Yes  No

2. Is the member under the care of a renal specialist?  Yes  No

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**Section III. Please complete for growth hormone requests for growth hormone deficiency in adult members.**

Please provide information regarding diagnostic tests and assessments including type of growth hormone stimulation test performed, date, and results.

Stimulation Test \_\_\_\_\_ Peak Result \_\_\_\_\_ Date \_\_\_\_\_

Stimulation Test \_\_\_\_\_ Peak Result \_\_\_\_\_ Date \_\_\_\_\_

IGF-1 level \_\_\_\_\_ Reference Range \_\_\_\_\_ Date \_\_\_\_\_

IGFBP-3 level \_\_\_\_\_ Reference Range \_\_\_\_\_ Date \_\_\_\_\_

1. Has pituitary imaging revealed abnormalities?

Yes (Please attach medical records documenting abnormality.)  No

2. Has the member experienced a symptom consistent with growth hormone deficiency?  Yes  No

If yes, please describe. \_\_\_\_\_

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**Section IV. Please complete for growth hormone requests for HIV-related wasting.**

Current height \_\_\_\_\_ Current weight \_\_\_\_\_ Date \_\_\_\_\_ Premorbid weight \_\_\_\_\_ Date \_\_\_\_\_

1. Is decreased caloric intake the etiology of the cachexia or wasting?  Yes  No

If yes, has member attempted therapy with dronabinol or megestrol acetate? If so, provide dates and duration. If not, please explain why.

2. Have other causes of weight loss been excluded including: gastrointestinal tract opportunistic infections, decrease in food intake due to oral, pharyngeal, esophageal lesions or candidiasis, gonadal dysfunction, adverse effects due to medications, or psychosocial factors.  Yes  No
3. Is the member under the care of an Infectious Disease specialist?  Yes  No
4. Is the member receiving concurrent antiretroviral therapy?  Yes  No

**Section V. Please complete for Increlex requests.**

Height \_\_\_\_\_ cm                                      Date \_\_\_\_\_                                      SD below mean for age \_\_\_\_\_  
 IGF-1 level \_\_\_\_\_                                      Reference Range \_\_\_\_\_                                      Date \_\_\_\_\_  
 Peak growth hormone level \_\_\_\_\_                                      Provocative Agent \_\_\_\_\_                                      Date \_\_\_\_\_

1. Is the member under the care of a Pediatric Endocrinologist or other specialist trained to diagnose and treat growth disorders?  
 Yes. Please specify. \_\_\_\_\_  
 No. Please indicate why not. \_\_\_\_\_
2. Does the member have open epiphyses?  
 Yes. Please attach most recent bone age, if available.  
 No. Please indicate clinical rationale for continued treatment.  
 \_\_\_\_\_
3. Have secondary forms of IGF-1 deficiency such as growth hormone deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids been ruled out?  
 Yes.  
 No. Please indicate clinical rationale for Increlex (mecasermin) in the presence of any of these conditions.  
 \_\_\_\_\_

**Section VI. Please complete for requests for any indication not listed above.**

Please describe the medical necessity for the use of growth hormone or Increlex in this member including trials and outcomes of any alternative treatments (if appropriate).

\_\_\_\_\_  
 \_\_\_\_\_

**Section VII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

\_\_\_\_\_  
 \_\_\_\_\_

**Prescriber information**

Last name\* \_\_\_\_\_ First name\* \_\_\_\_\_ MI \_\_\_\_\_  
 NPI\* \_\_\_\_\_ Individual MH Provider ID \_\_\_\_\_  
 DEA No. \_\_\_\_\_ Office Contact Name \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail address \_\_\_\_\_  
 Telephone No.\* \_\_\_\_\_ Fax No.\* \_\_\_\_\_

\* Required

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**Prescribing provider's attestation, signature, and date**

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

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

**Signature required** \_\_\_\_\_

Printed name of prescribing provider \_\_\_\_\_ Date \_\_\_\_\_