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.**

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)

☐ Genotropin
☐ Genotropin Miniquick
☐ Humatrope
☐ Increlex
☐ Norditropin Flexpro
☐ Nutropin AQ Nuspin
☐ Omnitrope
☐ Saizen
☐ Saizen Click.easy
☐ Serostim
☐ Skytrofa
☐ Zomacton
☐ Zorbtive

Dose and frequency of medication requested ____

Duration of therapy ____

Cartridge/vial strength ____

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

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

Indication for Increlex (Check all that apply.)

☐ Growth failure with severe primary IGF-1 deficiency
☐ Growth hormone gene deletion with neutralizing antibodies to growth hormone
☐ Other (Section VI or any section that may apply) ____________________________________

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

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

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. ____

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.

   ____

over

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*

over

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 ________________________