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

Print Clear

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.

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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).

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_____

Section VII. Please complete for Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizen Click.easy, Serostim, Skytrofa, Zomacton, and Zorbtive requests.

Please provide clinical rationale for use of the requested agent instead of Genotropin.

_____
_____
_____

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 _____