



Prior Authorization Request Administrative Information

Member Information

Last name First name MI

Member ID Date of birth

Sex assigned at birth Female Male "X" or Intersex

Current gender Female Male Transgender male Transgender female Other

Place of residence Home Nursing facility Other

Race/ethnicity Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan Contact Information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, Children's Medical Security Plan, and Health Safety Net Plan
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<input type="checkbox"/> MassHealth Drug Utilization Review Program Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

<input type="checkbox"/> Fallon Health Online Prior Authorization: go.covermyeds.com/OptumRx Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
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<input type="checkbox"/> Health New England Online Prior Authorization: go.covermyeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

<input type="checkbox"/> Mass General Brigham Health Plan Online Prior Authorization (Non-Specialty Drugs): go.covermyeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555

<input type="checkbox"/> Tufts Health Plan Online Prior Authorization: point32health.promptpa.com Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
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<input type="checkbox"/> WellSense Health Plan Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822
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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.

Medication information

Medication requested (check one)

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

Dose and frequency of medication requested

Duration of therapy

Cartridge/vial strength

Indication for Growth Hormone agent (Check all that apply or include ICD-10 code, if applicable.)

- | | |
|---|--|
| <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) | <input type="text"/> |

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 | <input type="text"/> |

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	<input type="text"/>	Peak Result	<input type="text"/>	Date	<input type="text"/>
Stimulation Test	<input type="text"/>	Peak Result	<input type="text"/>	Date	<input type="text"/>
IGF-1 level	<input type="text"/>	Reference Range	<input type="text"/>	Date	<input type="text"/>
IGFBP-3 level	<input type="text"/>	Reference Range	<input type="text"/>	Date	<input type="text"/>

1. Is the member 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 the member 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	<input type="text"/>	Peak Result	<input type="text"/>	Date	<input type="text"/>
Stimulation Test	<input type="text"/>	Peak Result	<input type="text"/>	Date	<input type="text"/>
IGF-1 level	<input type="text"/>	Reference Range	<input type="text"/>	Date	<input type="text"/>
IGFBP-3 level	<input type="text"/>	Reference Range	<input type="text"/>	Date	<input type="text"/>

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.

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 <input type="text"/> cm	Date <input type="text"/>	SD below mean for age <input type="text"/>
IGF-1 level <input type="text"/>	Reference Range <input type="text"/>	Date <input type="text"/>
Peak growth hormone level <input type="text"/>	<input type="text"/>	Date <input type="text"/>
	Provocative Agent <input type="text"/>	

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 Humatrope, Norditropin Flexpro, Nutropin AQ Nuspin, Omnitrope, Saizen, Saizen Click.easy, Serostim, Skytrofa, Sogroya, and Zomacton requests.

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

Section VIII. Please complete for Sogroya or Ngenla requests.

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

Section IX. Please complete and provide documentation for exceptions to Step Therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes No

If yes, please provide details for the previous trial.

Drug name

Dates/duration of use

Did the member experience any of the following? Adverse reaction Inadequate response

Briefly describe details of adverse reaction or inadequate response.

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member?

Yes. Please provide details.

No

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

Prescriber Information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
Email address	<input type="text"/>				
Telephone No.*	<input type="text"/>	Fax No.*	<input type="text"/>		

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

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 _____

Printed name of prescribing provider Date

(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)