



**Clinical and PDL Non-Preferred Prior Authorization for Growth Hormones
 Adult Requests**

Preferred	Non-Preferred, Prior Authorization Required
Genotropin® (somatropin) Genotropin® MiniQuick (somatropin) Norditropin® FlexPro (somatropin) Omnitrope® (somatropin)	Humatrope® (somatropin) Nutropin® AQ (somatropin) Nutropin AQ NuSpin® (somatropin) Saizen® (somatropin) Zomacton® (somatropin)

Beneficiary Information

Name: _____
 Medicaid ID #: _____ Date of Birth: _____

Pharmacy Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____
 Requested Drug: _____ NDC: _____

Endocrinologist Information

Name: _____ Medicaid ID #: _____
 NPI #: _____ Phone #: _____ Fax #: _____

Clinical Prior Authorization Information (required for all agents)

1. Please provide medical documentation from endocrinologist.
2. Please provide the diagnosis for which the growth hormone is being prescribed (ICD-9 code alone is not adequate):

3. Please provide the results of two provocative stimulation studies:
 (secretagogue testing should confirm peak growth hormone concentration <5ng/mL)

Date of Studies: _____

<input type="checkbox"/> Insulin: _____	Normal Range: _____
<input type="checkbox"/> L-Dopa: _____	Normal Range: _____
<input type="checkbox"/> GEREf/Arginine: _____	Normal Range: _____

4. Please provide IGF-1 or IGFBP-3 Value:
 Date of Test: _____
- | | |
|---|---------------------|
| <input type="checkbox"/> IGF-1: _____ | Normal Range: _____ |
| <input type="checkbox"/> IGFBP-3: _____ | Normal Range: _____ |

5. Please provide MRI if indicated.



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

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PDL Non-Preferred Prior Authorization Information (required for non-preferred agents)

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

Patient has a medical intolerance to preferred drug. Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____

Patient has had an inadequate response to preferred drug. Name of preferred agent patient tried: _____

An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need: _____

Prescriber's Signature: _____ **Date:** _____

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**