



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

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

- Please provide the following information along with this completed form:
  - Evaluation by pediatric endocrinologist or pediatrician with endocrinology only practice.
  - Copy of growth curve.
  - Radiological evidence of open epiphyseal growth plates for boys >16 years of age and girls >15 years of age.
  - Lab values related to medical diagnosis.
  - MRI if indicated
  - Target height
  - Height velocity and percentiles (SD). Attach a copy of printout or form
- Please provide the diagnosis for which the growth hormone is being prescribed (ICD-9 code alone is not adequate):  
 \_\_\_\_\_
- Please provide growth rate over 6 month period (include at least 3 measurements):
 

Date: _____	Height (in centimeters): _____
Date: _____	Height (in centimeters): _____
Date: _____	Height (in centimeters): _____



**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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4. Please provide the following lab values:

T4:	_____	Date:	_____	Normal Range:	_____
TSH:	_____	Date:	_____	Normal Range:	_____
IGF-1:	_____	Date:	_____	Normal Range:	_____
IGFBP-3 (optional):	_____	Date:	_____	Normal Range:	_____

5. Please provide the results of at least two stimulation studies with two different secretagogues:

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

**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.**