



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

Clinical and PDL Non-Preferred Prior Authorization for Growth Hormones Pediatric Renewal 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)

- Please provide the following information along with this completed form:
 (information must be from within the past 6 months)
 History and physical and clinical notes from endocrinologist
 Growth curve
 Height velocity
 Radiological evidence of open epiphyseal growth plates for boys >16 years of age and girls >15 years of age
- 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): _____
- Is beneficiary compliant with growth hormone therapy? Yes No



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Pediatric Renewal Requests**

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.**