

**INDIANA HEALTH COVERAGE PROGRAMS PHARMACY BENEFIT
GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM FOR CHILDREN (< 18 Years of Age)**



Pharmacy Benefit Management (PBM) Call Center
4550 Victory Lane
Indianapolis, IN 46203
Phone: (866) 879-0106 Fax: (866) 780-2198



□□ / □□ / □□□□

Today's Date

****All sections must be completed or the request will be returned****

Patient's Medicaid #	□□□□□□□□□□	Date of Birth	□□ / □□ / □□□□
Patient's Name	Prescriber's Name		
Prescriber's IN License #	□□□□□□□□	Specialty	
Prescriber's NPI #	□□□□□□□□□□	Prescriber's Signature	
Return Fax #	□□□□ - □□□□ - □□□□	Return Phone #	□□□□ - □□□□ - □□□□

Requested Drug: _____ **Dosage:** _____ **Length of Therapy:** _____

Note: Humatrope is non-preferred unless patient has a diagnosis of SHOX deficiency. All other growth hormone agents are preferred. If Humatrope is medically necessary or required for a particular patient, please provide a brief summary for use of Humatrope over the preferred agents:

Patient: Male Female

- Please select the diagnosis:
 - Growth hormone deficiency
 - Turner's syndrome
 - Noonan syndrome
 - SHOX (Short stature homeobox-containing gene) deficiency
 - Prader-Willi syndrome
 - Children born small for gestational age
 - Growth retardation with chronic renal insufficiency
 - Other _____ Diagnosis code _____
- Current height _____ (in) Height 6 months prior _____ (in) Height 3 months prior _____ (in)
- Bone Age: 15-16 or less in male; 14 – 15 or less in female
Required documentation: X-Ray or preferably written documentation
- Epiphyses open Yes No
Required documentation: X-Ray or preferably written documentation

If diagnosis is "other", then the following must be provided:

- Documentation of height measurement prior to growth hormone therapy of more than 2.0 standard deviation below population mean for given age (growth chart)
- Documentation indicating growth rate of 5 cm/year or less before start of therapy
- MRI or preferably written documentation indicating NO expanding intracranial lesions or tumor
- Biochemical evidence or testing supporting the diagnosis

CONFIDENTIAL INFORMATION

This facsimile transmission (and attachments) may contain protected health information from the Indiana Health Coverage Programs (IHCP), which is intended only for the use of the individual or entity named in this transmission sheet. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure, or reproduction of this information is prohibited.

Effective: January 1, 2010

Revised: April 2011