Prior Authorization Request

Nevada Medicaid – OptumRx

Growth Hormone for Recipients Under Age 21

Submit fax request to: 855-455-3303

Purpose: For a prescribing physician to request a prior authorization for growth hormones for a recipient under age 21.

Questions: If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	
Phone:	Fax (required):	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:	Strength:	
Dosage:	Duration:	

Diagnosis **(REQUIRED)**:

☐ Turner's Syndrome ☐ Prader-Willi Syndrome ☐ Chronic renal insufficiency ☐ Hypothalmic pituitary disease
☐ Small for gestational age ☐ Idiopathic short stature ☐ Other (document): _____

COVERAGE CRITERIA

Please check the applicable boxes to indicate each item as true for the recipient:

This request is for *(check one)*: ☐ Initial therapy ☐ Continuing therapy

The recipient has been evaluated by a: ☐ Pediatric nephrologist ☐ Pediatric endocrinologist

All other causes for short stature have been ruled out. ☐ Yes ☐ No

Epiphyses: ☐ Open ☐ Closed

The recipient has received a renal transplant. ☐ Yes ☐ No

The recipient has deficiencies in three or more pituitary axes (TSH, LH, FSH, ACTH, ADH). ☐ Yes ☐ No

The recipient is receiving adequate replacement therapy for other hormone deficiencies if required. ☐ Yes ☐ No

The recipient has expanding intracranial lesions or tumor formation. ☐ Yes ☐ No

The recipient's bone age is >2 standard deviations below the mean for age. ☐ Yes ☐ No

The recipient's height is >2.25 standard deviations below mean for age. ☐ Yes ☐ No

The recipient's height is >2 standard deviations below the mid-parenteral height percentile. ☐ Yes ☐ No

The recipient's growth velocity is <25th percentile for bone age or normal height for gender. ☐ Yes ☐ No

The recipient's growth rate on treatment is >2 cm compared to the untreated rate (continuing therapy only). ☐ Yes ☐ No

Please provide information regarding any diagnostic tests or assessments performed:

☐	**Growth hormone stimulation test**	Date:_____	Level:_____ng/ml
☐	**IGF-1**	Date:_____	Level:_____ng/ml
☐	**IGF-BP3**	Date:_____	Level:_____ng/ml
☐	**Blood glucose**	Date:_____	Level:_____mg/dl

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

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