

**Biosynthetic Growth Hormone Approval Request Form**  
Human Growth Hormone Injections

Children diagnosed with growth failure due to a lack of adequate endogenous growth hormone secretion may be approved for therapy upon physician documentation of medical necessity. Requests for prior approval must include a current growth chart and will receive review based on the following criteria:

- Physical stature less than 3rd percentile on growth chart;
- Growth velocity less than 4 cm/year (ages 5-10 years);
- Bone age 2 years delayed with epiphyses indicating growth potential;
- Normal thyroid and other pituitary function studies (May be corrected with medication);
- Two pharmacological provocative tests indicating growth hormone deficiency (less than 10ng/ml GH);
- Below normal Somatomedin C level or IGF/BP3

Prior authorization for growth hormone therapy for girls with Turner's Syndrome may be approved without evidence of deficient growth hormone production on provocative testing if other criteria are met. Documentation of chromosomal abnormality must be submitted.

Nutropin® therapy may be approved for the treatment of growth failure associated with chronic renal insufficiency up to the time of renal transplantation upon physician documentation of diagnosis and growth failure.

Approval may be granted for a period of up to 12 months. If an extension of benefits is needed the physician must submit a progress report indicating growth and maturation. This must include the date the patient was last seen, the patient's height and weight at that time and a growth chart documenting growth over, at a minimum, the previous three years.

This form may be used for requests for prior approval of:

- Protropin®
- Nutropin®
- Humatrope®
- Genotropin®
- Saizen®

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
TEXAS MEDICAID/CHIP VENDOR DRUG PROGRAM

**Biosynthetic Growth Hormone Approval Request Form**

Complete all items or the form will be returned for additional information.  
Please document reason why any information is not available.

**Client Name:** \_\_\_\_\_ **Medicaid ID#:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
\_\_\_\_\_ **Gender:** \_\_\_\_\_  
\_\_\_\_\_ **Telephone:** \_\_\_\_\_  
**Parent/Guardian:** \_\_\_\_\_

**Primary Diagnosis (ICD-9-CM Plus Description)**

253.2 Panhypopituitarism  253.3 Pituitary Dwarfism  
 253.7 Iatrogenic Pituitary Disorders  758.6 Turners's Syndrome  
 Other \_\_\_\_\_

Name of growth hormone: \_\_\_\_\_ Dose (mg/kg): \_\_\_\_\_  
Frequency of administration: \_\_\_\_\_ Date Patient last seen: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Height Percentile: \_\_\_\_\_ Weight Percentile: \_\_\_\_\_

Growth velocity (submit updated growth chart including growth in the previous 3 years):  
Before therapy: \_\_\_\_\_ cm/yr After therapy: \_\_\_\_\_ cm/yr

Are the epiphyses closed? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Bone age: \_\_\_\_\_ Chronological age: \_\_\_\_\_ Date Performed: \_\_\_\_\_  
Thyroid function normal? \_\_\_\_\_ Yes \_\_\_\_\_ No On Replacement Therapy: \_\_\_\_\_ Yes \_\_\_\_\_ No  
Patient on glucocorticoid therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No  
IGF/BP3 result: \_\_\_\_\_

Two stimulation tests, or one test using two provocative stimuli, with growth hormone values equal to or less than 10 ng/ml:  
Test #1 \_\_\_\_\_ Peak: \_\_\_\_\_ ng/ml Date: \_\_\_\_\_  
Test #2 \_\_\_\_\_ Peak: \_\_\_\_\_ ng/ml Date: \_\_\_\_\_

**A request for girls with Turner's Syndrome must have documentation of chromosomal study indicating XO chromosome.**

**PHYSICIAN SECTION MUST BE COMPLETED**

<b>Name:</b> _____	<b>Tx. License #:</b> _____
<b>Address:</b> _____	<b>Phone:</b> _____
_____	<b>Fax:</b> _____

I certify that the indicated treatment is medically necessary, and I will be supervising the patient's treatment.  
This is an:  Initial Certification  
 Recertification

<b>Physician Signature:</b> _____	<b>Date</b> _____
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**FORM SUBMITTAL INSTRUCTIONS**

Drug Use Review (H-630)  
HHSC Medicaid/CHIP Vendor Drug Program  
PO Box 85200, Austin, Texas 78708-5200  
Fax: 512-491-1962