

**Growth Hormone (GH) for Children
Nebraska Medicaid Prior Authorization Process and Criteria**

HOW IS AUTHORIZATION REQUESTED?

PRESCRIBER ---

By Faxing Completed Form to Nebraska Total Care, Inc.: The prescriber must request authorization by faxing the patient's diagnosis and the other required information on a DHHS Fax Form. Requested data must be noted on the fax form. Data provided only on attachments is not acceptable. This form must be signed by the prescriber.

FAX: 1-866-759-4115

(A fax request form is available at nebraska.fhsc.com.)

OR

By Providing the Pharmacist with the Needed Information: The prescriber may provide the needed information on a DHHS Fax Form to the pharmacist. The pharmacist will fax the information to Nebraska Total Care. Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.

PHARMACIST ---

The dispensing pharmacist may use medical information provided by the prescriber to request authorization directly from the Nebraska Total Care Clinical Call Center by faxing the patient's diagnosis and the other required information on a DHHS Fax Form. Requested data must be noted on the fax form. Data provided only on attachments is not acceptable. The pharmacy must maintain this written information for the same length of time as the prescription record is required to be maintained by statute or regulation. Electronic storage/imaging shall meet this requirement.

FAX: 1-866-759-4115

(A fax request form is available at nebraska.fhsc.com.)

Initial approval will be granted for 6 months. Renewal may be granted for a period of up to 12 months, dependent upon compliance and response. Renewal may be denied for non-compliance or failure to demonstrate growth rate at least 2cm/yr > pre-treatment rate.

WHAT INFORMATION IS NEEDED?

All requests for approval must be submitted in writing. Requests will only be accepted from the prescriber or dispensing pharmacy on the forms available as stated above. Preprinted forms from manufacturers or patient assistance agencies will not be accepted. If other insurance coverage exists, a copy of the approval/denial from the primary carrier(s) must accompany the request for prior authorization. All new Growth Hormone (GH) products approved subsequent to this bulletin shall be subject to these criteria.

Growth hormone (GH) will only be approved for patients less than 18 years of age and when dispensed by an in-state provider. Coverage of GH must be approved prior to dispensing and the Department may deny coverage of any product dispensed prior to approval. Requests for renewal must include pharmacy dispensing/shipping records as well as documentation of compliance. Dispensed quantity may not exceed a 31 day supply. Current pharmacy program standards for early refill shall apply.

GH therapy for children will be authorized for certain FDA approved, medically necessary indications and will be limited to FDA approved doses. An evaluation by a Pediatric Endocrinologist or Pediatric Nephrologist is mandatory for initiation of GH treatment.

Requests for prior approval of GH therapy for children may be considered medically necessary for the following conditions:

- Documented endogenous GH deficiency
- Chronic Renal Failure awaiting transplantation (CRF)
- Turner's Syndrome (TS)
- Prader-Willi Syndrome (PWS)
- Panhypopituitarism

Growth Hormone (GH) for Children Nebraska Medicaid Prior Authorization Process and Criteria

The following FDA approved indications for GH therapy are considered NOT medically necessary and requests will be denied:

- Patients born small for gestational age (SGA)
- Idiopathic short stature (ISS)

Requests for approval must include a current growth chart and results of all required diagnostic testing and will be reviewed based on the following criteria:

All requests for children:

- Evaluation by a pediatric endocrinologist or pediatric nephrologist
- Bone age < 16 years for males or < 14 years for females.
- Open epiphyses
- All causes for short stature, other than GH deficiency are ruled out.
- Thyroid & cortisol levels must be within normal range or patient is receiving adequate replacement therapy.

Growth Hormone Deficiency (GHD) including Pituitary Dwarfism:

- Physical stature < 3rd percentile.
- Bone age \geq 2 standard deviations delayed with epiphyses indicating growth potential.
- Family history (must include parents' heights).
- Growth velocity < 4cm/yr (ages 5-10 years).
- Exclusive of infants, 12 months old or less with hypoglycemia, two pharmaceutical provocative tests (or 1 test using 2 different agents) indicating response 10 ng/ml.
- Serum IGF-I OR IGFBP3 below normal values.
- Current height < midparental height:
 - Males: $(\text{Father's height} + \text{Mother's height} + 13\text{cm}) \div 2$
 - Females: $(\text{Mother's height} + \text{Father's height} - 13\text{cm}) \div 2$

Pre-transplant chronic renal failure (CRF):

- GFR < 30mL/min (CRF only)

Diagnosis of Turner's Syndrome:

- Diagnosed by karyotyping

Diagnosis of Prader-Willi Syndrome:

- Diagnosed by karyotyping

Panhypopituitarism

Hypothalamic-pituitary disease of structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial radiation:

- Failure of at least two GH stimulation tests [peak GH level <10 ng/mL].
- Has at least one documented low IGF-1 level below normal range for patient's age as per range on submitted lab document
- Has deficiencies in 3 or more pituitary axes (i.e., TSH, LH, FSH, ACTH, ADH).