



**NEBRASKA MEDICAID PROGRAM REQUEST FOR PRIOR AUTHORIZATION OF  
PAYMENT INSULIN-LIKE GROWTH FACTOR (IGF) FOR CHILDREN**

PRESCRIBING PHYSICIAN:

MEDICAID RECIPIENT:

Name: \_\_\_\_\_  
First Last

Name: \_\_\_\_\_  
First Last

Phone #: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Medicaid # □□□□□□□□□□

Fax #: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Date of Birth: □□/□□/□□□□

Physician Specialty \_\_\_\_\_

Other Insurance Information ID# \_\_\_\_\_

NPI # \_\_\_\_\_

(NOTE: Patient must be 18 years or younger.)

**PARTICIPATING PHARMACY:**

Name: \_\_\_\_\_

Phone #: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Fax #: (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**DRUG/CLINICAL INFORMATION:**

Request Date: \_\_\_\_\_

**Initial**

**Renewal:** Growth velocity (cm/yr): Current \_\_\_\_\_; Pre-treatment \_\_\_\_\_. Compliant with IGF therapy: Y/N.

Renewal may be denied for non-compliance with therapy and/or failure to demonstrate a current growth rate at least 2 cm/yr > pre-treatment growth rate.

Drug Requested \_\_\_\_\_ Strength \_\_\_\_\_ Daily dose \_\_\_\_\_

**Primary Diagnosis:**

**Primary Insulin-Like Growth Factor (IGF-1) Deficiency (IGFD)**

Height Standard Deviation Score: \_\_\_\_\_

Basal IGF-1 Standard Deviation Score: \_\_\_\_\_

IGF-1 level & reference range: \_\_\_\_\_

Provocative testing: (Initial Request Only)

Agent 1 \_\_\_\_\_ Peak \_\_\_\_\_ Date \_\_\_\_\_

Agent 2 \_\_\_\_\_ Peak \_\_\_\_\_ Date \_\_\_\_\_

**Growth Hormone Gene Deletion with Neutralizing Antibodies to GH**

**Other** (specify) \_\_\_\_\_

Date of Most Recent Clinic Visit \_\_\_\_\_

**Diagnostic testing (attach all results):**

Physical Stature Percentile \_\_\_\_\_ ; Height \_\_\_\_\_ cm; Weight \_\_\_\_\_ kg; Tanner Stage

Bone Age \_\_\_\_ Yr \_\_\_\_ Mo; Chronological Age \_\_\_\_ Yr \_\_\_\_ Mo;

Date of Scan \_\_\_\_\_ Open epiphyses: Y / N

Mother's Height \_\_\_\_\_ cm; Father's Height \_\_\_\_\_ cm.

Growth Velocity \_\_\_\_\_ cm/yr

Thyroid level & reference range \_\_\_\_\_ ACTH level & reference range \_\_\_\_\_

What, if any, hormone replacement therapy, is patient receiving: \_\_\_\_\_

\_\_\_\_\_  
Attach growth chart, showing trend over a minimum of the past 3 years.

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. I also attest that I have obtained authorization to release the above information. I will be supervising the patient's treatment.

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Please note:** Nebraska Total Care may request chart documentation to verify the above information.

**Submit requests to:** Envolve Pharmacy Solutions      Fax: 1-866-399-0929 Tel: 1-844-330-7852