



West Virginia Medicaid  
Drug Prior Authorization Form

<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

Growth Hormone Prior Authorization Form  
for members under 21 years of age

Rational Drug Therapy Program  
WVU School of Pharmacy  
PO Box 9511 HSCN  
Morgantown, WV 26506  
Fax: 1-800-531-7787  
Phone: 1-800-847-3859

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Name (Last)	(First)	(MI)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy Name (if applicable)
<input type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

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**Important Notes:** Preauthorization for medical necessity does not guarantee payment.  
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Drug Name	Strength	Route of Administration
<input type="text"/>	<input type="text"/>	<input type="text"/>

Directions	Diagnosis	ICD Diagnosis Code (if available)
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Initial Authorization:** All products in this category, whether preferred or non-preferred, require prior authorization. If the requested agent is non-preferred, the Preferred Drug List Prior Authorization Form must be completed in addition.

Current Height (in cm)	Current Weight (in kg)	Current Bone Age	Date of X-Ray
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Epiphyses open? <input type="checkbox"/> Yes <input type="checkbox"/> No (not approved)	Expanding intracranial lesions or tumors? <input type="checkbox"/> Yes (not approved) <input type="checkbox"/> No
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Date of GH stimulus test:	Test type:	Results (ng/ml)
<input type="text"/>	<input type="text"/>	<input type="text"/>

IFG-1 level (percentile for chronological age)	Standard deviation from mean for chronological age (growth chart is required)	Tanner Scale Rating:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please choose only one of the following diagnosis areas:

Growth Hormone Deficiency

Neurosecretory Growth Retardation

Turner's Syndrome (attach documentation, required)

Growth Retardation due to Chronic Renal Insufficiency

Does the patient have an irreversible renal insufficiency with a creatinine clearance rate of less than 75 ml/min per 1.7 m<sup>2</sup> (pre-renal transplant?)  Yes  No (not approved)

Non-Growth Hormone Deficiency (Idiopathic short stature)

Father's Height (in cm)  Mother's Height (in cm)

Is the child's ability to participate in the basic activities of daily living limited by his/her height?  Yes (explain)  No (not approved)

Other

Other pertinent Information (attached additional pages if necessary)

**Continuation of Treatment:** All products in this category, whether preferred or non-preferred, require prior authorization. If the requested agent is non-preferred, the Preferred Drug List Prior Authorization Form must be completed in addition.

Current Height (in cm)	Current Weight (in kg)	Current Bone Age	Date of X-Ray
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Epiphyses open?  Yes  No (not approved) Expanding intracranial lesions or tumors?  Yes (not approved)  No

Current rate of growth (cm/past 12 months) growth chart is required  Tanner Scale Rating:

Other pertinent Information (attached additional pages if necessary)

I am a board certified pediatric endocrinologist

**Attestation:** Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

Check here for electronic signature

Prescriber or Pharmacist Signature

Date:   
(MM/DD/YYYY)