Growth Hormones

Goal(s):

- Restrict use of growth hormone (GH) for funded diagnoses where there is medical evidence of effectiveness and safety.

NOTE: Treatment with growth hormone (GH) is included only for children with: pituitary dwarfism, Turner's syndrome, Prader-Willi-syndrome, Noonan's syndrome, short stature homeobox-containing gene (SHOX), chronic kidney disease (stage 3 or higher) and those with renal transplant. Treatment with GH should continue only until adult height as determined by bone age is achieved. Treatment is not included for isolated deficiency of human growth hormone or other conditions in adults.

Length of Authorization:

- Up to 12 months

Requires PA:

- Non-preferred drugs

Covered Alternatives:

- All GH products require prior authorization for OHP coverage. GH treatment for adults is not funded by the OHP.
- Preferred alternatives are listed at www.orpdl.org/drugs/

Initial Approval Criteria		
1. What is the diagnosis being treated?	Record ICD10 code	
2. Is the patient an adult (>18 years of age)?	Yes: Pass to RPh. Deny; not funded by the OHP	No: Go to #3
3. Is this a request for initiation of growth hormone?	Yes: Go to #4	No: Go to Renewal Criteria
4. Is the prescriber a pediatric endocrinologist or pediatric nephrologist?	Yes: Go to #5	No: Pass to RPh. Deny; medical appropriateness
5. Is the diagnosis promotion of growth delay in a child with 3rd degree burns?	Yes: Document and send to DHS Medical Director for review and pending approval	No: Go to #6

Initial Approval Criteria		
6. Is the diagnosis one of the following? • Turner's syndrome (ICD10 Q969) • Noonan's syndrome (ICD10 E7871-7872, Q872-873, Q875, Q8781, Q8789, Q898) • Prader-Willi syndrome (PWS) (ICD10 Q871) • Pituitary dwarfism (ICD10 E230) • Short stature homeobox-containing gene (SHOX) (ICD10 R6252) • Chronic kidney disease (CKD, Stage ≥3) (ICD10 N183-N185) • Renal transplant (ICD10 Z940)	Yes: Document and go to #7	No: Pass to RPh. Deny; not funded by the OHP.
7. If male, is bone age <16 years? If female, is bone age <14 years?	Yes: Go to #8	No: Pass to RPh. Deny; medical appropriateness
8. Is there evidence of non-closure of epiphyseal plate?	Yes: Go to #9	No: Pass to RPh. Deny; medical appropriateness
9. Is the product requested preferred?	Yes: Approve for up to 12 months	No: Go to #10
10. Will the prescriber consider a change to a preferred product? <u>Message</u>: • Preferred products to not require a copay. • Preferred products are evidence-based reviewed for comparative effectiveness and safety by the Pharmacy and Therapeutics (P&T) Committee.	Yes: Inform prescriber of covered alternatives in class and approve for up to 12 months.	No: Approve for up to 12 months

Renewal Criteria		
1. Document approximate date of initiation of therapy and diagnosis (if not already done).		
2. Is growth velocity greater than 2.5 cm per year?	Yes: Go to #3	No: Pass to RPh. Deny; medical appropriateness
3. Is male bone age <16 years or female bone age <14 years?	Yes: Go to #4	No: Pass to RPh. Deny; medical appropriateness

4. Is the product requested preferred?	Yes: Approve for up to 12 months	No: Go to #5
5. Will the prescriber consider a change to a preferred product? Message: • Preferred products do not require a copay. • Preferred products are evidence based reviewed for comparative effectiveness and safety by the Pharmacy and Therapeutics (P&T) Committee.	Yes: Inform prescriber of covered alternatives in class and approve for up to 12 months	No: Approve for up to 12 months

---

P&T / DUR Review: *9/15; 9/14; 9/10; 5/10; 9/08; 2/06; 11/03; 9/03*
Implementation: *10/15; 1/1/11, 7/1/10, 4/15/09, 10/1/03, 9/1/06; 10/1/03*