

**Texas Prior Authorization Program
Clinical Criteria**

Drug/Drug Class**Growth Hormone****Clinical Criteria Information Included in this Document****Excluding Serostim[®] / Zorbtive[®]**

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
- **Prior authorization criteria logic:** a description of how the prior authorization request will be evaluated against the clinical criteria rules
- **Logic diagram:** a visual depiction of the clinical criteria logic
- **Supporting tables:** a collection of information associated with the steps within the criteria (diagnosis codes, procedure codes, and therapy codes); provided when applicable

Serostim

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Note: Click the hyperlink to navigate directly to that section.

Zorbtive

- **Drugs requiring prior authorization:** the list of drugs requiring prior authorization for this clinical criteria
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Revision Notes

- Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.) on each 'Drug Requiring PA'



Growth Hormone Excluding Serostim / Zorbtive Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization		
Label Name	NDC	GCN
GENOTROPIN 12 MG CARTRIDGE	00013264681	10554
GENOTROPIN MINIQUICK 0.2 MG	00013264902	50177
GENOTROPIN MINIQUICK 0.4 MG	00013265002	50187
GENOTROPIN MINIQUICK 0.8 MG	00013265202	50207
GENOTROPIN MINIQUICK 1.2 MG	00013265402	21450
GENOTROPIN MINIQUICK 1.4 MG	00013265502	21451
GENOTROPIN MINIQUICK 1.6 MG	00013265602	21452
GENOTROPIN MINIQUICK 1.8 MG	00013265702	21453
GENOTROPIN MINIQUICK 2 MG	00013265802	21454
GENOTROPIN MINIQUICK 0.6 MG	00013265102	50197
GENOTROPIN 5 MG CARTRIDGE	00013262681	63408
GENOTROPIN MINIQUICK 1 MG	00013265302	50217
HUMATROPE 5 MG VIAL	00002733511	25963
HUMATROPE 6 MG CARTRIDGE	00002814701	25969
HUMATROPE 12 MG CARTRIDGE	00002814801	00575
HUMATROPE 24 MG CARTRIDGE	00002814901	25957
NORDITROPIN NORDIFLEX 30 MG/3	00169770311	25816
NORDITROPIN FLEXPPO 5 MG/1.5	00169770421	24145
NORDITROPIN FLEXPPO 15 MG/1.5	00169770821	24147
NORDITROPIN FLEXPPO 10 MG/1.5	00169770521	24146
NUTROPIN AQ PEN CARTRIDGE	50242004314	17475
NUTROPIN AQ 20 MG/2ML PEN CART	50242007301	99320
NUTROPIN AQ NUSPIN 10 PEN CART	50242007401	17475
NUTROPIN AQ NUSPIN 5 PEN CART	50242007501	27846
NUTROPIN AQ NUSPIN 20 PEN CART	50242007601	99320
OMNITROPE 5 MG/1.5 ML CRTG	00781300107	92386
OMNITROPE 5 MG/1.5 ML CRTG	00781300126	92386
OMNITROPE 10 MG/1.5 ML CRTG	00781300407	92366
OMNITROPE 10 MG/1.5 ML CRTG	00781300426	92366
OMNITROPE 5.8 MG VIAL	00781400436	93215
SAIZEN 5 MG VIAL	44087100502	25955
SAIZEN 8.8 MG CLICK.EASY CARTG	44087108001	23695

Drugs Requiring Prior Authorization		
Label Name	NDC	GCN
SAIZEN 8.8 MG VIAL	44087108801	12767
TEV-TROPIN 5 MG VIAL	57844071319	25955

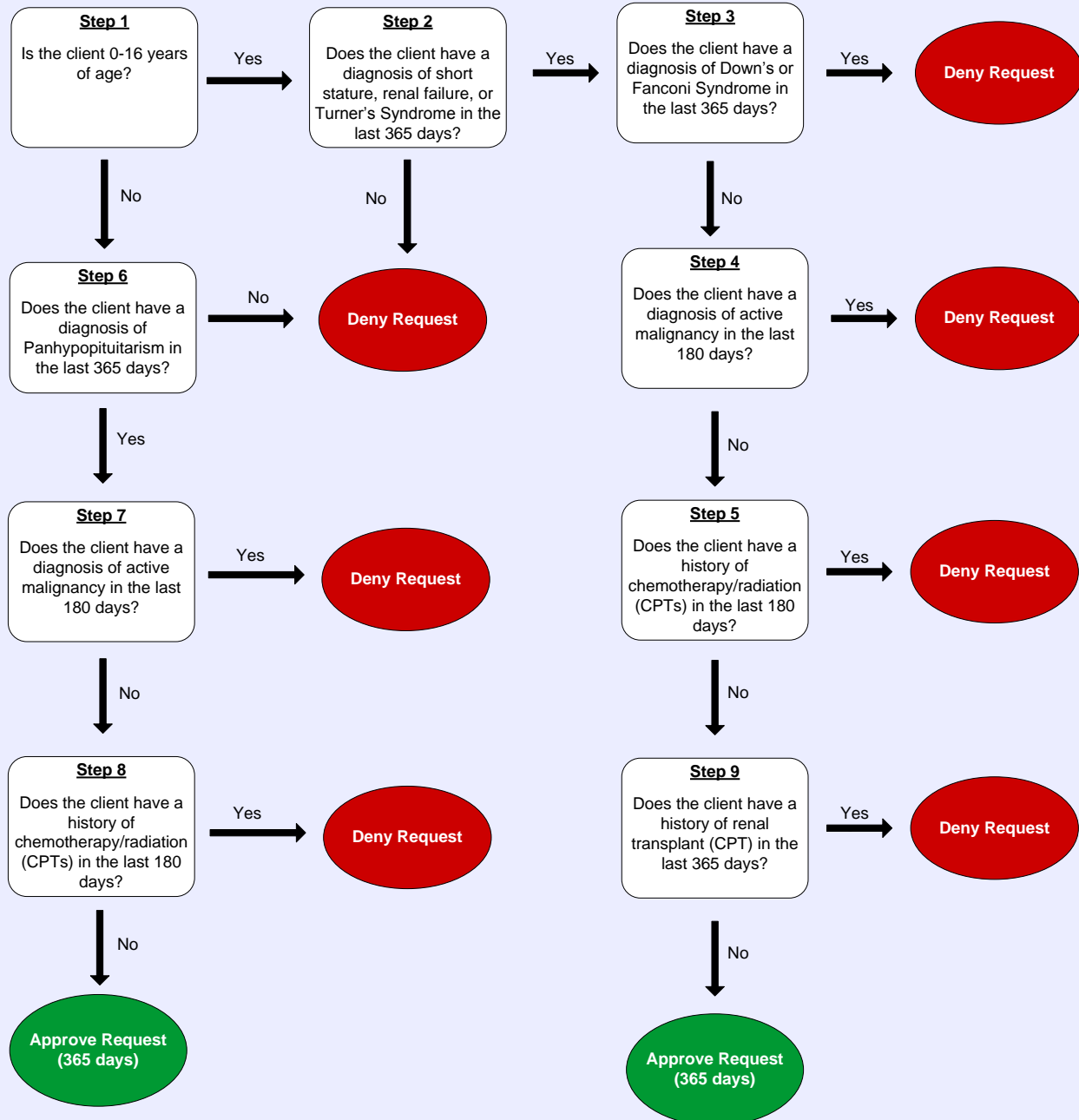


Growth Hormone Excluding Serostim / Zorbtive Clinical Criteria Logic

1. Is the client 0 to 16 (> 0 and ≤ 16) years of age?
 Yes (Go to #2)
 No (Go to #6)
2. Does the client have a diagnosis of short stature, renal failure, or Turner's Syndrome in the last 365 days?
 Yes (Go to #3)
 No (Deny)
3. Does the client have a diagnosis of Down's or Fanconi Syndrome in the last 365 days?
 Yes (Deny)
 No (Go to #4)
4. Does the client have a diagnosis of active malignancy in the last 180 days?
 Yes (Deny)
 No (Go to #5)
5. Does the client have a history of chemotherapy/radiation (CPTs) in the last 180 days?
 Yes (Deny)
 No (Go to #9)
6. Does the client have a diagnosis of Panhypopituitarism in the last 365 days?
 Yes (Go to #7)
 No (Deny)
7. Does the client have a diagnosis of active malignancy in the last 180 days?
 Yes (Deny)
 No (Go to #8)
8. Does the client have a history of chemotherapy/radiation (CPTs) in the last 180 days?
 Yes (Deny)
 No (Approve – 365 days)
9. Does the client have a history of a renal transplant (CPT) in the last 365 days?
 Yes (Deny)
 No (Approve – 365 days)



Growth Hormone Excluding Serostim / Zorbtive Clinical Criteria Logic Diagram





Growth Hormone Excluding Serostim / Zorbtive Clinical Criteria Supporting Tables

Step 2 (diagnosis of short stature, renal failure, or Turner's Syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
Short Stature, Renal Failure, or Turner's Syndrome Diagnoses	
ICD-10 Code	Description
B520	PLASMODIUM MALARIAE MALARIA WITH NEPHROPATHY
E0821	DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH DIABETIC NEPHROPATHY
E0822	DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH DIABETIC CHRONIC KIDNEY DISEASE
E0829	DIABETES MELLITUS DUE TO UNDERLYING CONDITION WITH OTHER DIABETIC KIDNEY COMPLICATION
E0921	DRUG OR CHEMICAL INDUCED DIABETES MELLITUS WITH DIABETIC NEPHROPATHY
E0922	DRUG OR CHEMICAL INDUCED DIABETES MELLITUS WITH DIABETIC CHRONIC KIDNEY DISEASE
E0929	DRUG OR CHEMICAL INDUCED DIABETES MELLITUS WITH OTHER DIABETIC KIDNEY COMPLICATION
E231	DRUG-INDUCED HYPOPIUITARISM
E893	POSTPROCEDURAL HYPOPIUITARISM
M3214	GLOMERULAR DISEASE IN SYSTEMIC LUPUS ERYTHEMATOSUS
M3215	TUBULO-INTERSTITIAL NEPHROPATHY IN SYSTEMIC LUPUS ERYTHEMATOSUS
M3504	SICCA SYNDROME WITH TUBULO-INTERSTITIAL NEPHROPATHY
N008	ACUTE NEPHRITIC SYNDROME WITH OTHER MORPHOLOGIC CHANGES
N020	RECURRENT AND PERSISTENT HEMATURIA WITH MINOR GLOMERULAR ABNORMALITY
N021	RECURRENT AND PERSISTENT HEMATURIA WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N022	RECURRENT AND PERSISTENT HEMATURIA WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS
N023	RECURRENT AND PERSISTENT HEMATURIA WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N024	RECURRENT AND PERSISTENT HEMATURIA WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N025	RECURRENT AND PERSISTENT HEMATURIA WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N026	RECURRENT AND PERSISTENT HEMATURIA WITH DENSE DEPOSIT DISEASE
N027	RECURRENT AND PERSISTENT HEMATURIA WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS

Step 2 (diagnosis of short stature, renal failure, or Turner's Syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
Short Stature, Renal Failure, or Turner's Syndrome Diagnoses	
ICD-10 Code	Description
N028	RECURRENT AND PERSISTENT HEMATURIA WITH OTHER MORPHOLOGIC CHANGES
N029	RECURRENT AND PERSISTENT HEMATURIA WITH UNSPECIFIED MORPHOLOGIC CHANGES
N030	CHRONIC NEPHRITIC SYNDROME WITH MINOR GLOMERULAR ABNORMALITY
N031	CHRONIC NEPHRITIC SYNDROME WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N032	CHRONIC NEPHRITIC SYNDROME WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS
N033	CHRONIC NEPHRITIC SYNDROME WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N034	CHRONIC NEPHRITIC SYNDROME WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N035	CHRONIC NEPHRITIC SYNDROME WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N036	CHRONIC NEPHRITIC SYNDROME WITH DENSE DEPOSIT DISEASE
N037	CHRONIC NEPHRITIC SYNDROME WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
N038	CHRONIC NEPHRITIC SYNDROME WITH OTHER MORPHOLOGIC CHANGES
N039	CHRONIC NEPHRITIC SYNDROME WITH UNSPECIFIED MORPHOLOGIC CHANGES
N040	NEPHROTIC SYNDROME WITH MINOR GLOMERULAR ABNORMALITY
N041	NEPHROTIC SYNDROME WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N042	NEPHROTIC SYNDROME WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS
N043	NEPHROTIC SYNDROME WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N044	NEPHROTIC SYNDROME WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N045	NEPHROTIC SYNDROME WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N046	NEPHROTIC SYNDROME WITH DENSE DEPOSIT DISEASE
N047	NEPHROTIC SYNDROME WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
N048	NEPHROTIC SYNDROME WITH OTHER MORPHOLOGIC CHANGES
N049	NEPHROTIC SYNDROME WITH UNSPECIFIED MORPHOLOGIC CHANGES
N050	UNSPECIFIED NEPHRITIC SYNDROME WITH MINOR GLOMERULAR ABNORMALITY
N051	UNSPECIFIED NEPHRITIC SYNDROME WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N052	UNSPECIFIED NEPHRITIC SYNDROME WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS

Step 2 (diagnosis of short stature, renal failure, or Turner's Syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
Short Stature, Renal Failure, or Turner's Syndrome Diagnoses	
ICD-10 Code	Description
N053	UNSPECIFIED NEPHRITIC SYNDROME WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N054	UNSPECIFIED NEPHRITIC SYNDROME WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N055	UNSPECIFIED NEPHRITIC SYNDROME WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N056	UNSPECIFIED NEPHRITIC SYNDROME WITH DENSE DEPOSIT DISEASE
N057	UNSPECIFIED NEPHRITIC SYNDROME WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
N058	UNSPECIFIED NEPHRITIC SYNDROME WITH OTHER MORPHOLOGIC CHANGES
N059	UNSPECIFIED NEPHRITIC SYNDROME WITH UNSPECIFIED MORPHOLOGIC CHANGES
N060	ISOLATED PROTEINURIA WITH MINOR GLOMERULAR ABNORMALITY
N061	ISOLATED PROTEINURIA WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N062	ISOLATED PROTEINURIA WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS
N063	ISOLATED PROTEINURIA WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N064	ISOLATED PROTEINURIA WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N065	ISOLATED PROTEINURIA WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N066	ISOLATED PROTEINURIA WITH DENSE DEPOSIT DISEASE
N067	ISOLATED PROTEINURIA WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
N068	ISOLATED PROTEINURIA WITH OTHER MORPHOLOGIC LESION
N069	ISOLATED PROTEINURIA WITH UNSPECIFIED MORPHOLOGIC LESION
N070	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH MINOR GLOMERULAR ABNORMALITY
N071	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH FOCAL AND SEGMENTAL GLOMERULAR LESIONS
N072	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH DIFFUSE MEMBRANOUS GLOMERULONEPHRITIS
N073	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH DIFFUSE MESANGIAL PROLIFERATIVE GLOMERULONEPHRITIS
N074	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH DIFFUSE ENDOCAPILLARY PROLIFERATIVE GLOMERULONEPHRITIS
N075	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH DIFFUSE MESANGIOCAPILLARY GLOMERULONEPHRITIS
N076	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH DENSE DEPOSIT DISEASE

Step 2 (diagnosis of short stature, renal failure, or Turner's Syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
Short Stature, Renal Failure, or Turner's Syndrome Diagnoses	
ICD-10 Code	Description
N077	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH DIFFUSE CRESCENTIC GLOMERULONEPHRITIS
N078	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH OTHER MORPHOLOGIC LESIONS
N079	HEREDITARY NEPHROPATHY, NOT ELSEWHERE CLASSIFIED WITH UNSPECIFIED MORPHOLOGIC LESIONS
N08	GLOMERULAR DISORDERS IN DISEASES CLASSIFIED ELSEWHERE
N140	ANALGESIC NEPHROPATHY
N141	NEPHROPATHY INDUCED BY OTHER DRUGS, MEDICAMENTS AND BIOLOGICAL SUBSTANCES
N142	NEPHROPATHY INDUCED BY UNSPECIFIED DRUG, MEDICAMENT OR BIOLOGICAL SUBSTANCE
N143	NEPHROPATHY INDUCED BY HEAVY METALS
N144	TOXIC NEPHROPATHY, NOT ELSEWHERE CLASSIFIED
N150	BALKAN NEPHROPATHY
N158	OTHER SPECIFIED RENAL TUBULO-INTERSTITIAL DISEASES
N159	RENAL TUBULO-INTERSTITIAL DISEASE, UNSPECIFIED
N16	RENAL TUBULO-INTERSTITIAL DISORDERS IN DISEASES CLASSIFIED ELSEWHERE
N171	ACUTE KIDNEY FAILURE WITH ACUTE CORTICAL NECROSIS
N172	ACUTE KIDNEY FAILURE WITH MEDULLARY NECROSIS
N181	CHRONIC KIDNEY DISEASE, STAGE 1
N182	CHRONIC KIDNEY DISEASE, STAGE 2 (MILD)
N183	CHRONIC KIDNEY DISEASE, STAGE 3 (MODERATE)
N184	CHRONIC KIDNEY DISEASE, STAGE 4 (SEVERE)
N185	CHRONIC KIDNEY DISEASE, STAGE 5
N186	END STAGE RENAL DISEASE
N189	CHRONIC KIDNEY DISEASE, UNSPECIFIED
N19	UNSPECIFIED KIDNEY FAILURE
N250	RENAL OSTEODYSTROPHY
N251	NEPHROGENIC DIABETES INSIPIDUS
N259	DISORDER RESULTING FROM IMPAIRED RENAL TUBULAR FUNCTION, UNSPECIFIED
N261	ATROPHY OF KIDNEY (TERMINAL)
N269	RENAL SCLEROSIS, UNSPECIFIED
P059	NEWBORN AFFECTED BY SLOW INTRAUTERINE GROWTH, UNSPECIFIED
Q871	CONGENITAL MALFORMATION SYNDROMES PREDOMINANTLY ASSOCIATED WITH SHORT STATURE

Step 2 (diagnosis of short stature, renal failure, or Turner's Syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
Short Stature, Renal Failure, or Turner's Syndrome Diagnoses	
ICD-10 Code	Description
Q960	KARYOTYPE 45, X
Q961	KARYOTYPE 46, X ISO (XQ)
Q962	KARYOTYPE 46, X WITH ABNORMAL SEX CHROMOSOME, EXCEPT ISO (XQ)
Q963	MOSAICISM, 45, X/46, XX OR XY
Q964	MOSAICISM, 45, X/OTHER CELL LINE(S) WITH ABNORMAL SEX CHROMOSOME
Q968	OTHER VARIANTS OF TURNER'S SYNDROME
Q969	TURNER'S SYNDROME, UNSPECIFIED
R6252	SHORT STATURE (CHILD)

Step 3 (diagnosis of Down's or Fanconi Syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
ICD-10 Code	Description
E7200	DISORDERS OF AMINO-ACID TRANSPORT, UNSPECIFIED
E7201	CYSTINURIA
E7202	HARTNUP'S DISEASE
E7204	CYSTINOSIS
E7209	OTHER DISORDERS OF AMINO-ACID TRANSPORT
Q900	TRISOMY 21, NONMOSAICISM (MEIOTIC NONDISJUNCTION)
Q901	TRISOMY 21, MOSAICISM (MITOTIC NONDISJUNCTION)
Q902	TRISOMY 21, TRANSLOCATION
Q909	DOWN SYNDROME, UNSPECIFIED

Step 4 (diagnosis of active malignancy)	
Required diagnosis: 1	
Look back timeframe: 180 days	
Active Malignancy Diagnoses	
ICD-10 Code	Description
C410	MALIGNANT NEOPLASM OF BONES OF SKULL AND FACE
C73	MALIGNANT NEOPLASM OF THYROID GLAND
C786	SECONDARY MALIGNANT NEOPLASM OF RETROPERITONEUM AND PERITONEUM

Step 4 (diagnosis of active malignancy)	
Required diagnosis: 1	
Look back timeframe: 180 days	
Active Malignancy Diagnoses	
ICD-10 Code	Description
C7932	SECONDARY MALIGNANT NEOPLASM OF CEREBRAL MENINGES
C7940	SECONDARY MALIGNANT NEOPLASM OF UNSPECIFIED PART OF NERVOUS SYSTEM
C7949	SECONDARY MALIGNANT NEOPLASM OF OTHER PARTS OF NERVOUS SYSTEM

Step 5 (history of chemotherapy / radiation procedural code)	
Required procedure: 1	
Look back timeframe: 180 days	
Chemotherapy / Radiation Procedures	
CPT Code	Description
77261	RADIATION THERAPY PLANNING
77262	RADIATION THERAPY PLANNING
77263	RADIATION THERAPY PLANNING
77280	SET RADIATION THERAPY FIELD
77285	SET RADIATION THERAPY FIELD
77290	SET RADIATION THERAPY FIELD
77295	SET RADIATION THERAPY FIELD
77299	RADIATION THERAPY PLANNING
77300	RADIATION THERAPY DOSE PLAN
77301	RADIOLTHERAPY DOS PLAN, IMRT
77305	RADIATION THERAPY DOSE PLAN
77310	RADIATION THERAPY DOSE PLAN
77315	RADIATION THERAPY DOSE PLAN
77321	RADIATION THERAPY PORT PLAN
77326	RADIATION THERAPY DOSE PLAN
77327	RADIATION THERAPY DOSE PLAN
77328	RADIATION THERAPY DOSE PLAN
77331	SPECIAL RADIATION DOSIMETRY
77332	RADIATION TREATMENT AID(S)
77333	RADIATION TREATMENT AID(S)
77334	RADIATION TREATMENT AID(S)
77336	RADIATION PHYSICS CONSULT
77338	DESIGN MLC DEVICE FOR IMRT

Step 5 (history of chemotherapy / radiation procedural code)	
Required procedure: 1	
Look back timeframe: 180 days	
Chemotherapy / Radiation Procedures	
CPT Code	Description
77370	RADIATION PHYSICS CONSULT
77371	SRS, MULTISOURCE
77372	SRS, LINEAR BASED
77373	SBRT DELIVERY
77399	EXTERNAL RADIATION DOSIMETRY
77401	RADIATION TREATMENT DELIVERY
77402	RADIATION TREATMENT DELIVERY
77403	RADIATION TREATMENT DELIVERY
77404	RADIATION TREATMENT DELIVERY
77406	RADIATION TREATMENT DELIVERY
77407	RADIATION TREATMENT DELIVERY
77408	RADIATION TREATMENT DELIVERY
77409	RADIATION TREATMENT DELIVERY
77411	RADIATION TREATMENT DELIVERY
77412	RADIATION TREATMENT DELIVERY
77413	RADIATION TREATMENT DELIVERY
77414	RADIATION TREATMENT DELIVERY
77416	RADIATION TREATMENT DELIVERY
77417	RADIOLOGY PORT FILM(S)
77418	RADIATION TX DELIVERY, IMRT
77421	STEREOSCOPIC X-RAY GUIDANCE
77422	NEUTRON BEAM TX, SIMPLE
77423	NEUTRON BEAM TX, COMPLEX
77427	RADIATION TX MANAGEMENT, X5
77431	RADIATION THERAPY MANAGEMENT
77432	STEREOTACTIC RADIATION TRMT
77435	SBRT MANAGEMENT
77470	SPECIAL RADIATION TREATMENT
77499	RADIATION THERAPY MANAGEMENT
77520	PROTON TRMT, SIMPLE W/O COMP
77522	PROTON TRMT, SIMPLE W/COMP
77523	PROTON TRMT, INTERMEDIATE
77525	PROTON TREATMENT, COMPLEX
96401	CHEMO, ANTI-NEOPL, SQ/IM

Step 5 (history of chemotherapy / radiation procedural code)	
Required procedure: 1	
Look back timeframe: 180 days	
Chemotherapy / Radiation Procedures	
CPT Code	Description
96402	CHEMO HORMON ANTINEOPL SQ/IM
96405	CHEMO INTRALESIONAL, UP TO 7
96406	CHEMO INTRALESIONAL OVER 7
96409	CHEMO, IV PUSH, SNGL DRUG
96411	CHEMO, IV PUSH, ADDL DRUG
96413	CHEMO, IV INFUSION, 1 HR
96415	CHEMO, IV INFUSION, ADDL HR
96416	CHEMO PROLONG INFUSE W/PUMP
96417	CHEMO IV INFUS EACH ADDL SEQ
96420	CHEMO, IA, PUSH TECHNIQUE
96422	CHEMO IA INFUSION UP TO 1 HR
96423	CHEMO IA INFUSE EACH ADDL HR
96425	CHEMOTHERAPY INFUSION METHOD
96440	CHEMOTHERAPY, INTRACAVITARY
96445	CHEMOTHERAPY, INTRACAVITARY
96450	CHEMOTHERAPY, INTO CNS
96521	REFILL/MAINT, PORTABLE PUMP
96542	CHEMOTHERAPY INJECTION
96549	CHEMOTHERAPY, UNSPECIFIED
J9000	DOXORUBICIN HCL INJECTION
J9001	DOXORUBICIN HCL LIPOSOME INJ
J9010	ALEMTUZUMAB INJECTION
J9015	ALDESLEUKIN INJECTION
J9020	ASPARAGINASE INJECTION
J9027	CLOFARABINE INJECTION
J9033	BENDAMUSTINE INJECTION
J9040	BLEOMYCIN SULFATE INJECTION
J9041	BORTEZOMIB INJECTION
J9045	CARBOPLATIN INJECTION
J9050	CARMUSTINE INJECTION
J9055	CETUXIMAB INJECTION
J9060	CISPLATIN 10 MG INJECTION
J9062	CISPLATIN 50 MG INJECTION
J9065	INJ CLADRIBINE PER 1 MG

Step 5 (history of chemotherapy / radiation procedural code)	
Required procedure: 1	
Look back timeframe: 180 days	
Chemotherapy / Radiation Procedures	
CPT Code	Description
J9070	CYCLOPHOSPHAMIDE 100 MG INJ
J9080	CYCLOPHOSPHAMIDE 200 MG INJ
J9090	CYCLOPHOSPHAMIDE 500 MG INJ
J9091	CYCLOPHOSPHAMIDE 1.0 GRM INJ
J9092	CYCLOPHOSPHAMIDE 2.0 GRM INJ
J9093	CYCLOPHOSPHAMIDE LYOPHILIZED
J9094	CYCLOPHOSPHAMIDE LYOPHILIZED
J9095	CYCLOPHOSPHAMIDE LYOPHILIZED
J9096	CYCLOPHOSPHAMIDE LYOPHILIZED
J9097	CYCLOPHOSPHAMIDE LYOPHILIZED
J9098	CYTARABINE LIPOSOME INJ
J9100	CYTARABINE HCL 100 MG INJ
J9110	CYTARABINE HCL 500 MG INJ
J9120	DACTINOMYCIN INJECTION
J9130	DACARBAZINE 10 MG INJ
J9140	DACARBAZINE 200 MG INJ
J9150	DAUNORUBICIN INJECTION
J9151	DAUNORUBICIN CITRATE INJ
J9155	DEGARELIX INJECTION
J9160	DENILEUKIN DIFTITOX INJ
J9170	DOCETAXEL INJECTION
J9171	DOCETAXEL INJECTION
J9178	INJ, EPIRUBICIN HCL, 2 MG
J9181	ETOPOSIDE INJECTION
J9182	ETOPOSIDE 100 MG INJ
J9185	FLUDARABINE PHOSPHATE INJ
J9190	FLUOROURACIL INJECTION
J9200	FLOXURIDINE INJECTION
J9201	GEMCITABINE HCL INJECTION
J9206	IRINOTECAN INJECTION
J9207	IXABEPILONE INJECTION
J9208	IFOSFOMIDE INJECTION
J9211	IDARUBICIN HCL INJECTION
J9261	NELARABINE INJECTION

Step 5 (history of chemotherapy / radiation procedural code)	
Required procedure: 1	
Look back timeframe: 180 days	
Chemotherapy / Radiation Procedures	
CPT Code	Description
J9263	OXALIPLATIN
J9264	PACLITAXEL PROTEIN BOUND
J9265	PACLITAXEL INJECTION
J9266	PEGASPARGASE INJECTION
J9268	PENTOSTATIN INJECTION
J9280	MITOMYCIN 5 MG INJ
J9290	MITOMYCIN 20 MG INJ
J9291	MITOMYCIN 40 MG INJ
J9303	PANITUMUMAB INJECTION
J9305	PEMETREXED INJECTION
J9320	STREPTOZOCIN INJECTION
J9328	TEMOZOLOMIDE INJECTION
J9330	TEMSIROLIMUS INJECTION
J9340	THIOTEPA INJECTION
J9350	TOPOTECAN INJECTION
J9355	TRASTUZUMAB INJECTION
J9357	VALRUBICIN INJECTION
J9360	VINBLASTINE SULFATE INJ
J9370	VINCRISTINE SULFATE 1 MG INJ
J9375	VINCRISTINE SULFATE 2 MG INJ
J9380	VINCRISTINE SULFATE 5 MG INJ
J9390	VINORELBINE TARTRATE INJ
J9600	PORFIMER SODIUM INJECTION
J9999	CHEMOTHERAPY DRUG

Step 6 (diagnosis of Panhypopituitarism)	
Required diagnosis: 1	
Look back timeframe: 365 days	
ICD-9 Code	Description
2532	PANHYPOPITUITARISM
ICD-10 Code	Description
E230	HYPOPITUITARISM

Step 7 (diagnosis of active malignancy)**Required diagnosis: 1****Look back timeframe: 180 days**

For the list of diagnosis codes that pertain to this step, see the **Active Malignancy Diagnoses** table in this "Supporting Tables" section.

Note: Click the hyperlink to navigate directly to the table.

Step 8 (history of chemotherapy / radiation procedural code)**Required procedure: 1****Look back timeframe: 180 days**

For the list of procedure codes that pertain to this step, see the **Chemotherapy / Radiation Procedures** table in this "Supporting Tables" section.

Note: Click the hyperlink to navigate directly to the table.

Step 9 (history of renal transplant procedural code)**Required procedure: 1****Look back timeframe: 365 days**

CPT Code	Description
50300	REMOVAL OF DONOR KIDNEY
50300	REMOVE CADAVER DONOR KIDNEY
50320	REMOVE KIDNEY, LIVING DONOR
50340	REMOVAL OF KIDNEY
50360	TRANSPLANTATION OF KIDNEY
50365	TRANSPLANTATION OF KIDNEY
50370	REMOVE TRANSPLANTED KIDNEY
50380	REIMPLANTATION OF KIDNEY



Growth Hormone Serostim

Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization		
Label Name	NDC	GCN
SEROSTIM 4 MG VIAL	44087000407	63405
SEROSTIM 5 MG VIAL	44087000507	25955
SEROSTIM 6 MG VIAL	44087000607	25960

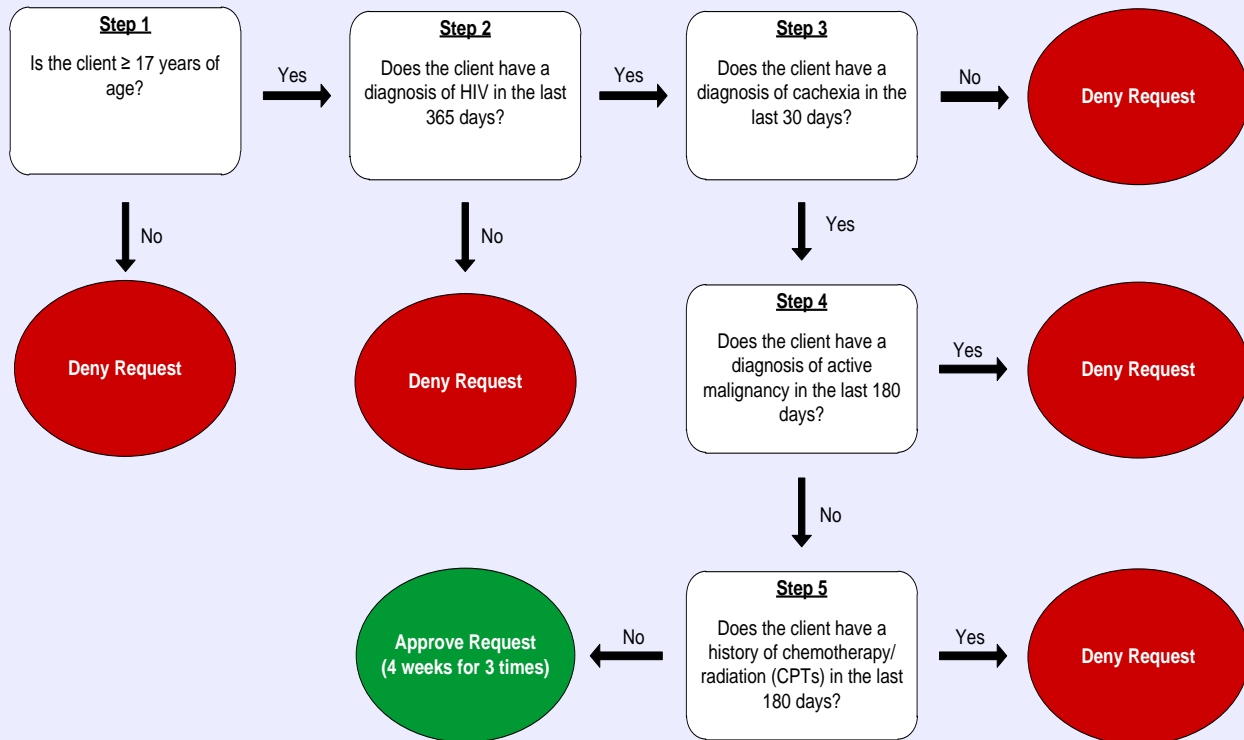


**Growth Hormone
Serostim
Clinical Criteria Logic**

1. Is the client greater than or equal to (\geq) 17 years of age?
 Yes (Go to #2)
 No (Deny)
2. Does the client have a diagnosis of HIV in the last 365 days?
 Yes (Go to #3)
 No (Deny)
3. Does the client have a diagnosis of cachexia in the last 30 days?
 Yes (Go to #4)
 No (Deny)
4. Does the client have a diagnosis of active malignancy in the last 180 days?
 Yes (Deny)
 No (Go to #5)
5. Does the client have a history of chemotherapy/radiation (CPTs) in the last 180 days?
 Yes (Deny)
 No (Approve – 4 weeks for 3 times)



Growth Hormone Serostim Clinical Criteria Logic Diagram





Growth Hormone Serostim

Clinical Criteria Supporting Tables

Step 2 (diagnosis of HIV) Required diagnosis: 1 Look back timeframe: 365 days	
ICD-10 Code	Description
B20	HUMAN IMMUNODEFICIENCY VIRUS [HIV] DISEASE

Step 3 (diagnosis of cachexia) Required diagnosis: 1 Look back timeframe: 30 days	
ICD-10 Code	Description
R64	CACHEXIA

Step 4 (diagnosis of active malignancy) Required diagnosis: 1 Look back timeframe: 180 days	
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For the list of diagnosis codes that pertain to this step, see the [Active Malignancy Diagnoses](#) table in the previous "Supporting Tables" section.

Note: Click the hyperlink to navigate directly to the table.

Step 5 (history of a chemotherapy / radiation procedural code) Required procedure: 1 Look back timeframe: 180 days	
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For the list of procedures that pertain to this step, see the [Chemotherapy / Radiation Procedures](#) table in the previous "Supporting Tables" section.

Note: Click the hyperlink to navigate directly to the table.



Growth Hormone Zorbtive

Drugs Requiring Prior Authorization

The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit TxVendorDrug.com/formulary/formulary-search.

Drugs Requiring Prior Authorization		
Label Name	NDC	GCN
ZORBTIVE 8.8 MG VIAL	44087338807	12767

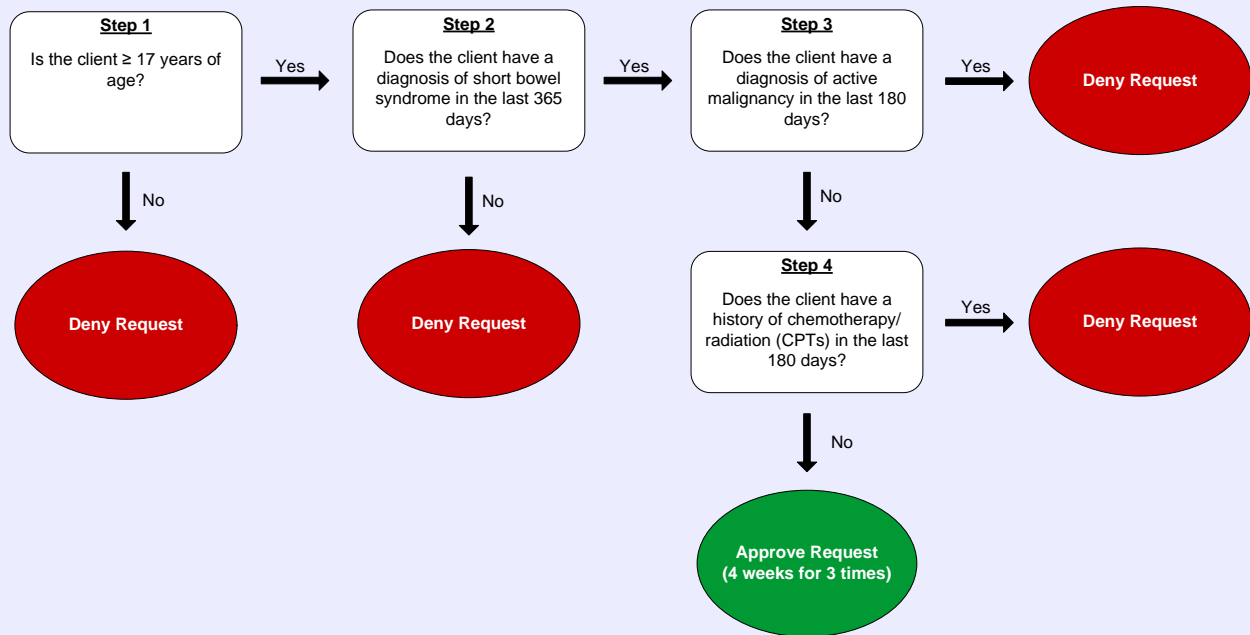


**Growth Hormone
Zorbtive
Clinical Criteria Logic**

1. Is the client greater than or equal to (\geq) 17 years of age?
 Yes (Go to #2)
 No (Deny)
2. Does the client have a diagnosis of short bowel syndrome in the last 365 days?
 Yes (Go to #3)
 No (Deny)
3. Does the client have a diagnosis of active malignancy in the last 180 days?
 Yes (Deny)
 No (Go to #4)
4. Does the client have a history of chemotherapy/radiation (CPTs) in the last 180 days?
 Yes (Deny)
 No (Approve – 4 weeks for 3 times)



Growth Hormone Zorbtive Clinical Criteria Logic Diagram





Growth Hormone Zorbtive

Clinical Criteria Supporting Tables

Step 2 (diagnosis of short bowel syndrome)	
Required diagnosis: 1	
Look back timeframe: 365 days	
ICD-10 Code	Description
K902	BLIND LOOP SYNDROME, NOT ELSEWHERE CLASSIFIED
K912	POSTSURGICAL MALABSORPTION, NOT ELSEWHERE CLASSIFIED

Step 3 (diagnosis of active malignancy)	
Required diagnosis: 1	
Look back timeframe: 180 days	

For the list of diagnoses that pertain to this step, see the [Active Malignancy Diagnoses](#) table in the previous "Supporting Tables" section.

Note: Click the hyperlink to navigate directly to the table.

Step 4 (history of a chemotherapy / radiation procedural code)	
Required diagnosis: 1	
Look back timeframe: 180 days	

For the list of procedure codes that pertain to this step, see the [Chemotherapy / Radiation Procedures](#) table in the previous "Supporting Tables" section.

Note: Click the hyperlink to navigate directly to the table.



Growth Hormone

Clinical Criteria References

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Publication History

The Publication History records the publication iterations and revisions to this document. Notes for the *most current revision* are also provided in the **Revision Notes** on the first page of this document.

Publication Date	Notes
01/31/2011	Initial publication and posting to website
02/04/2011	Corrected steps 3 and 4 in the "Clinical Edit Criteria Logic" section for Growth Hormones Excluding Serostim/Zorbtive
02/23/2011	Corrected step 2 in the "Clinical Edit Criteria Logic" section for Growth Hormones Excluding Serostim/Zorbtive
05/03/2012	<ul style="list-style-type: none"> Added new section to specify the drugs requiring prior authorization for each form of Zorbtive In the "Clinical Edit Supporting Tables" section for Growth Hormone Excluding Serostim / Zorbtive, revised tables to specify the diagnosis codes pertinent to steps 2, 3, 4, 7, and 8 of the logic diagram In the "Clinical Edit Supporting Tables" section for Growth Hormone Excluding Serostim / Zorbtive, revised tables to specify the procedure codes pertinent to steps 5, 6, and 9 of the logic diagram In the "Clinical Edit Supporting Tables" section for Serostim, revised tables to specify the diagnosis codes pertinent to steps 3, 4, and 5 of the logic diagram In the "Clinical Edit Supporting Tables" section for Serostim, revised table to specify the procedure codes pertinent to step 6 In the "Clinical Edit Supporting Tables" section for Zorbtive, revised tables to specify the diagnosis codes pertinent to steps 3 and 4 of the logic diagram In the "Clinical Edit Supporting Tables" section for Zorbtive, revised table to specify the procedure codes pertinent to step 5
05/22/2012	In the "Clinical Edit Supporting Tables" section for Growth Hormone Excluding Serostim/Zorbtive, updated table pertinent to step 2 to include Turner's Syndrome for ICD-9 code 7586
08/14/2013	Added step 9 in the "Clinical Edit Criteria Logic" section for Growth Hormones Excluding Serostim/Zorbtive
02/06/2014	Added Omnitrope 5.8mg vial and Omnitrope 10mg/1.5mL cartridge to the "Drugs Requiring Prior Authorization" section for Growth Hormone Excluding Serostim/Zorbtive
10/21/2014	Updated document to include NDCs for "Drugs Requiring Prior Authorization"
04/03/2015	Updated to include ICD-10s
03/29/2019	Updated to include formulary statement (The listed GCNS may not be an indication of TX Medicaid Formulary coverage. To learn the current formulary coverage, visit

Publication Date	Notes
	TxVendorDrug.com/formulary/formulary-search.) on each 'Drug Requiring PA' table