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**Fax completed prior authorization request form to** 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

# Growth Hormones
# Pharmacy Prior Authorization Request Form

**Do not copy for future use. Forms are updated frequently.**

**REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis**

| **Member Information** | | | |
|---|---|---|---|
| Member Name (first & last): | Date of Birth: | Gender: ☐ Male ☐ Female | Height: |
| Member ID: | City: | State: | Weight: |

| **Prescribing Provider Information** | | | |
|---|---|---|---|
| Provider Name (first & last): | Specialty: | NPI# | DEA# |
| Office Address: | City: | State: | Zip Code: |
| Office Contact: | Office Phone | Office Fax: | |

| **Dispensing Pharmacy Information** | | |
|---|---|---|
| Pharmacy Name: | Pharmacy Phone: | Pharmacy Fax: |

| **Requested Medication Information** | | | | | |
|---|---|---|---|---|---|
| ☐ **Genotropin®** | ☐ **Norditropin Flexpro®** | ☐ **Norditropin®** | ☐ **Nutropin AQ®** | ☐ **Humatrope®** | |
| ☐ **Omnitrope®** | ☐ Zomacton® | ☐ **Serostim®** | ☐ **Skytrofa®** | ☐ **Sogroya®** | ☐ **Ngenla®** |

| **Other, please specify:** | | |
|---|---|---|
| Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐Yes ☐ No | ICD-10 Code: | Diagnosis: |
| What medication(s) have been tried and failed for diagnosis? (please specify): | | |
| Does the member have an allergy to the inactive ingredients in the preferred medications? | ☐ Yes | ☐ No |

| Directions for Use: | Strength: | Dosage Form: |
|---|---|---|
| | Quantity: / Day Supply: | Duration of Therapy/Use: |

| **Turn-Around Time for Review** | |
|---|---|
| ☐ Standard – (24 hours) | ☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____ |

| **Clinical Information (select one of the following diagnoses)** | | | | | |
|---|---|---|---|---|---|
| **Panhypopituitarism:** | ☐ Cachexia, pituitary | ☐ Necrosis of pituitary (postpartum) | ☐ Pituitary insufficiency NOS | ☐ Sheehan's syndrome | ☐ Simmond's disease |
| **Pituitary dwarfism:** | ☐ Isolated deficiency of (human) growth hormone [HGH] | ☐ Lorain-Levi dwarfism) | | | |
| **Endocrine disorders – Other specified endocrine disorders:** | ☐ Pineal gland dysfunction | ☐ Progeria | ☐ Werner's syndrome | | |
| **Intermediate sex and pseudohermaphroditism:** | ☐ Gynandrism | ☐ Hermaphroditism | ☐ Ovotestis | ☐ Pseudohermaphroditism (male, female) | ☐ Pure gonadal dysgenesis |
| **Gonadal dysgenesis:** | ☐ Turner's Syndrome (female only) | ☐ XO syndrome | ☐ Ovarian dysgenesis | | |

| | | | |
|---|---|---|---|
| ☐ **Prader-Willi Syndrome (Genotropin and Norditropin Flexpro only)** | ☐ **CKD – stage 1, 2 or 3 (Nutropin only)** | ☐ **CKD – stage 4 or 5** | ☐ **SHOX (Humatrope only)** |
| ☐ **Idiopathic Short Stature (Requires submission of medical records)** | | | |

**Growth Hormone Stimulation Testing**

| | | | |
|---|---|---|---|
| **Pituitary Dwarfism:** | ☐ Member failed two kinds of growth hormone stimulation testing (required for all members) | ☐ Member is an adolescent with closed epiphyseal growth plates or an adult | ☐ Testing was done after growth hormone therapy has been suspended at least 3 months |

| | | |
|---|---|---|
| Are the kinds of stimulation tests performed, the result (lab value), reference range and date attached with the request? | ☐ Yes | ☐ No |

| | |
|---|---|
| **Papilledema:** | ☐ Provider is aware of the risk of intracranial hypertension and the role of fundoscopic examination to assess and monitor for papilledema. |

**Bone Age X-Rays (required regardless of diagnosis, but not for adults; x-ray does not have to be performed within a specific time frame)**

| | | |
|---|---|---|
| For pediatric members: is the bone x-ray report attached (unless the prescriber is a pediatric endocrinologist)? | ☐ Yes | ☐ No |
| For adolescent members (13 to 19 years of age): is the bone x-ray report attached (unless the prescriber is a pediatric endocrinologist)? | ☐ Yes | ☐ No |
| For adolescent members (13 to 19 years of age): have the epiphyseal growth plates closed? | ☐ Yes | ☐ No |

**NOTE**: Requests that do not meet clinical criteria will require further review and must include the patient's diagnosis including ICD-10, if available. Growth charts should be provided, if available, at time of review (ensure that the correct chart is being submitted based on the patient's age – for example., 0–3 vs 2–20) in addition to documentation of small for gestational age at birth, if appropriate.

**Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records**

**Signature affirms that information given on this form is true and accurate and reflects office notes.**

**Prescribing Provider's Signature:** _____ **Date:** _____

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.