



Request for Prior Authorization
GROWTH HORMONES

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s).

Preferred

- Boxes for Norditropin, Nutropin AQ Pen, Nutropin AQ NuSpin

Non- Preferred

- Boxes for Genotropin, Humatrope, Omnitrope, Saizen, Tev-Tropin, Zorbtive

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges):

Number of vials per month: Estimate length of therapy: Bone Age: Date of Bone Age Test: Epiphyses open? Height: Weight: Height percentile at time of diagnosis: Weight percentile: Is standard deviation 2.0 or more below mean height for chronological age or less than fifth percentile? MRI diagnosis: Date: Growth rate per year Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far: Please provide 2 stimuli tests and results:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid.