MHS PHARMACY BENEFIT
ADULT (≥18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication and Strength	Dosage	Treatment Duration

SOMATROPIN AGENTS – Initial Authorization

Please select one of the following:

☐ Member is transitioning from pediatric growth hormone therapy
Must meet all of the following
- Member has reached adult height
- Member stopped growth hormone therapy for at least 1 month before re-evaluation of the need for continued therapy
- Prescriber has determined that member will experience growth hormone deficiency into adulthood and would receive clinical benefit from continued growth hormone therapy

☐ Diagnosis of adult growth hormone deficiency
***The following documentation will be required for diagnosis of "growth hormone deficiency"**
- Biochemical evidence or testing supporting the diagnosis

☐ Diagnosis of short bowel syndrome (Zorbitive only)
***The following documentation will be required for diagnosis of "short bowel syndrome"**
- Documentation supporting the diagnosis of short bowel syndrome
- Documentation indicating patient is receiving specialized nutritional support

☐ Diagnosis of HIV wasting or cachexia (Serostim only)
***The following documentation will be required for diagnosis of "HIV wasting or cachexia"**
- Quantitative measurement of lean body mass using DEXA (dual energy X-ray absorptiometry) or BIA (bioelectric impedance analysis)

- Documentation of involuntary weight loss of >10% of baseline total body weight OR body cell mass <30% for initial approval

Member's current HAART regimen _____

Member has tried and failed the one of the following (include trial date, dose, frequency, duration, reason for failure): ☐ Dronabinol ☐ Megestrol ☐ Anabolic Steroids ☐ None ☐ Other

_____

_____

Please complete the following:

Current:	height: _____(inches)	weight:_____(lbs)
3 months prior:	height: _____(inches)	weight:_____(lbs)
6 months prior:	height: _____(inches)	weight:_____(lbs)

SOMATROPIN AGENTS – Reauthorization

Please select one of the following:

☐ Member has previously been transitioned from pediatric growth hormone therapy

☐ Member has a diagnosis of adult growth hormone deficiency and is continuing growth hormone

☐ Member has a diagnosis of short bowel syndrome and is continuing to receive specialized nutritional support **(documentation required)**

☐ Member has a diagnosis of HIV wasting or cachexia and is continuing growth hormone therapy

- Member's current HAART therapy _____
- Member has demonstrated an increase in total body weight or lean body mass from treatment baseline **(documentation required)**

Please complete the following:

Current:	height: _____(inches)	weight:_____(lbs)
3 months prior:	height: _____(inches)	weight:_____(lbs)
6 months prior:	height: _____(inches)	weight:_____(lbs)