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FLORIDA MEDICAID

Prior Authorization

Human Growth Hormone

***Preferred (with maximum age limit of 16 years)**:*
Genotropin, Saizen
***Non-Preferred**: Humatrope, Norditropin, Nutropin, Omnitrope, Tev-Tropin*
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number - -

Prescriber Fax Number - -

Drug: **Quantity:** **Dosage Frequency:**

Height: in or cm **Weight:** lbs or kg **BMI:** kg/m2

Date last seen by the prescribing endocrinologist:

Diagnosis: (Please check all that apply and submit progress notes.)

☐ **Documented growth hormone (GH) deficiency (treated by a board certified endocrinologists)**

- ☐ Lowered growth hormone levels secondary to the normal aging process, obesity or depression?
- ☐ Growth hormone deficiency due to pituitary disease, hypothalamic disease, trauma, surgery, radiation therapy, acquisition as an adult or diagnosis during childhood?
- ☐ Acquired Immunodeficiency Syndrome (AIDS) wasting or cachexia? (Please submit Human Growth for HIV Wasting in Adults (Serostim) Form)
- ☐ **Other:** **Diagnosis Code:**

☐ **Treatment of short bowel syndrome in patient receiving specialized nutrition support (Zorbtive®)**

- ☐ **Date Therapy Initiated:** (Authorization will consist of one four-week course of therapy.)

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Fill in all related test results below. Medical records and all related official lab reports (dated within the past 6 months) must be submitted. *(If the request is for continuation of therapy in a child, the growth information below must be provided.)*

Growth Velocity: _____ (SD) and _____ (cm/year) **Bone Age:** _____ (year) **Height:** _____ (%)

Growth Plate: ◯ Open or ◯ Closed

Mid-Parental Height: _____ [(father's height + mother's height) ÷ 2, plus 2.5 inches (male) or minus 2.5 inches (female)]

Providers must correct for Thyroid Stimulating Hormone (TSH) deficiency prior to conducting a stimulation test:

TSH: _____ mU/L **Normal Range:** _____ **Date:** _____

Stimulation Testing: *(Copies of official test results must be submitted)* The preferred stimulation test is the Insulin Tolerance Test (ITT). Levodopa and Clonidine are not adequate agents for adult testing.

Test 1: type _____ **Peak GH Value:** _____ ng / ml **Standard Peak:** _____ ng / ml **Date:** _____

Test 2: type _____ **Peak GH Value:** _____ ng / ml **Standard Peak:** _____ ng / ml **Date:** _____

Previous IGF-1 (if applicable) _____ ng / ml **Normal range (for age):** _____ **Date:** _____

Recent IGF-1: _____ ng / ml **Normal range (for age):** _____ **Date:** _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727