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MAGELLAN COMPLETE CARE

Prior Authorization

Human Growth Hormone

Maximum Length of Approval = Six Months

Preferred (with maximum age limit of 16 years): Genotropin, Saizen, Tev-Tropin

Non-Preferred: Humatrope, Norditropin, Nutropin

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 and Frequency of Dosing:** _____

Height: _____ in _____ cm **Weight:** _____ lbs _____ kgs **BMI %:** _____

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))
- ☐ 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.)

Diagnostic Testing: 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 ○ 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:** _____ **Date:** _____

Stimulation Testing: (Copies of official test results must be submitted)

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)**:** _____ mU/L **Normal range (for age):** _____ **Date:** _____

Recent IGF-1 (if applicable)**:** _____ mU/L **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 or mail completed forms to:

Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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