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



Note: This form must be completed by the prescribing provider.							
All sections must be completed or the request will be returned							
Patient's Medicaid #	tient's 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 imelines) 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 D		osage	Treatment Duration				
SOMATROPIN AGENTS – Initial Authorization							
SOMATROPIN AGENTS – Initial Authori	zation						
Please select one of the following:							
Please select one of the following:		mone therapy					
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	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	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)			

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