## 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



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		/		/		

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

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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 retro-active PA	Date(s) of service requested for retro-active 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 of	one of the following:
Member	is transitioning from pediatric growth hormone therapy
*Must n	neet 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
Please	select one of the following:
	Request is for a preferred agent
	Request is for a non-preferred agent with a product-specific indication: List indication:
	Prescriber would like to utilize a non-preferred agent over preferred agent based on the following medical justification:

	has a diagnos				<b></b>
	-		equired for diagnosi	-	=
	Biochemical ev select one of th		plicable testing suppo	orting the diagnosis	
		a preferred agent			
	•		ent with a product-spe	cific indication.	
	List indication:		ent with a product-spe		
			on-preferred agent ov	ver preferred agent	based on the following
	medical justific		p	p	
*The fol		-	chexia (Serostim only equired for diagnosi		ated wasting or
		easurement of lean	body mass using DE	EXA (dual energy X	-ray absorptiometry) or
	BIA (bioelectri	c impedance analys	sis)		
		n of involuntary weiç r initial approval	ght loss of >10% of b	aseline total body v	veight OR body cell
Member	r's current AIDS	S/HIV anti-retroviral	regimen:		
Member	has tried and	failed one of the foll	lowing (include trial d	ate, dose, frequenc	cy, duration, reason
for failur	re): 🗌 Drona	binol 🗌 Megestrol [	Anabolic Steroids	□ None □ Other (	(please explain)
For ALL indica			• •		to ensure there are no
For ALL indica			ey have performed all itiating growth hormo		
For ALL indica			itiating growth hormo	one therapy 🗌 Ye	s 🗌 No
For ALL indicates expanding intractions in the second seco	cranial lesions	or tumors prior to in	itiating growth hormo	one therapy	s 🗌 No ned all necessary
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For ALL indicates expanding intractions intractions intractions in the string to ensure initiating growth initiating growth Prescriber Signed Please completes Current 3 month 6 month 6 month 6 month 10 SOMATROPIN Please select of Current Please select of Current 10 Member Please select of Current 10 Member 10 Membe	cranial lesions re that this m th hormone th nature: e the following: t: hs prior: AGENTS – Re one of the following: select one of the Request is for	or tumors prior to in ember does not have height:	hereby attest the ave expanding intrace	hat I have perform cranial lesions or weight: weight: weight: hormone therapy	s D No ed all necessary tumors prior to(lbs)(lbs)

	Prescriber wou medical justifica		on-preferred agent ov	er preferred agent	based on the following
			ormone deficiency an	d is continuing gro	wth hormone
Please	select one of th	•			
	•	a preferred agent		alfia in dia atiana	
	List indication:		ent with a product-spe		
	Prescriber wou medical justifica		on-preferred agent ov	er preferred agent	based on the following
therapy	y		d wasting or cachexia	-	-
•			etroviral regimen:		
•		emonstrated an inc mentation require	rease in total body we e <b>d)</b>	eight or lean body	mass from treatment
			ey have performed all nitiating growth hormo		to ensure there are no es            No
	ure that this me vth hormone th		hereby attest that ave expanding intrac	nat I have perforn cranial lesions or	ned all necessary tumors prior to
Prescriber Sig	gnature:				
Please comple	te the following:				
Curre	nt:	height:	(inches)	weight:	(lbs)
3 mon	ths prior:	height:			
6 mon	ths prior:	height:	(inches)	weight:	(lbs)
SOGROYA (S	OMAPACITAN)	– Initial Authoriza	ation		
*The following	g documentatio		Yes D No for diagnosis of "ac testing supporting the		one deficiency"
Member is 18	years of age or c	older 🗌 Yes 🗌 N	lo		
🗌 Tria	one of the followi al and failure of A st products trialed	LL preferred soma	tropin products		

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Prescriber would like to utilize a Sogroya (somapacitan) over ALL preferred somatropin agents based on the following medical justification:
Prescriber attests that they have performed all necessary testing to ensure there are no expanding intracranial
lesions or tumors prior to initiating growth hormone therapy 🗌 Yes 🔲 No
I,hereby attest that I have performed all necessary testing to ensure that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.
Prescriber Signature:
SOGROYA (SOMAPACITAN) – Reauthorization
SOGROYA (SOMAPACITAN) – Reauthorization         Prescriber attests that they are continuing to monitor the member for intracranial tumor recurrence, progression of underlying disease, or malignant transformation of skin lesions, if appropriate
Prescriber attests that they are continuing to monitor the member for intracranial tumor recurrence, progression

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