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 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 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

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:

_____

_____

☐ Member has a diagnosis of adult growth hormone deficiency

***The following documentation will be required for diagnosis of "growth hormone deficiency"**

- Biochemical evidence or other applicable testing supporting the diagnosis

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:

_____

_____

☐ Diagnosis of HIV-associated wasting or cachexia (Serostim only)

***The following documentation will be required for diagnosis of "HIV- associated 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 AIDS/HIV anti-retroviral regimen: _____

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

_____

_____

For ALL indications* – 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: _____

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

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:

_____

_____

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

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:

  _____

  _____

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

- Member's current AIDS/HIV anti-retroviral regimen: _____
- Member has demonstrated an increase in total body weight or lean body mass from treatment baseline **(documentation required)**

For ALL indications* – 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: _____

Please complete the following:

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

SOGROYA (SOMAPACITAN) – Initial Authorization

Diagnosis of adult growth hormone deficiency ☐ Yes ☐ No

***The following documentation will be required for diagnosis of "adult growth hormone deficiency"**

- Biochemical evidence or other applicable testing supporting the diagnosis

Member is 18 years of age or older ☐ Yes ☐ No

Please select one of the following:

☐ Trial and failure of ALL preferred somatropin products

List products trialed:_____

☐ 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

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 ☐ 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: _____