Amerigroup
An Anthem Company

https://providers.amerigroup.com/TX

Growth Hormones Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information	2. Physician information
Patient name: ______________________	Prescribing physician: ______________________
Patient ID #: ______________________	Physician address: ______________________
Patient DOB: ______________________	Physician phone #: ______________________
Date of Rx: ______________________	Physician fax #: ______________________
Patient phone #: ______________________	Physician specialty: ______________________
Patient email address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician email address: ______________________

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			Specify:
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

- ☐ Yes ☐ No Is medication is being provided and billed at the physician's office?
- ☐ Yes ☐ No Does the patient have a diagnosis of Growth Hormone Deficiency in the last three years?
- ☐ Yes ☐ No Does the patient have a diagnosis of Idiopathic Short Stature in the last three years?
- ☐ Yes ☐ No Does the patient have a diagnosis of panhypopituitarism in the last three years?
- ☐ Yes ☐ No Does the patient have a diagnosis of SHOX deficiency, Turner syndrome, Noonan syndrome or Prader-Willi syndrome in the last three years?
- ☐ Yes ☐ No Does the patient have a diagnosis of Chronic Kidney Disease in the last three years?
- ☐ Yes ☐ No Does the patient have a history of rental transplant in the last three years?
- ☐ Yes ☐ No Does the patient have a diagnosis of active malignancy in the last 180 days?
- ☐ Yes ☐ No Does the patient have a history of chemotherapy/radiation in the last 180 days?
- ☐ Yes ☐ No Does the patient have a diagnosis of active proliferative or severe nonproliferative diabetic retinopathy in the last 365 days?
- ☐ Yes ☐ No Does the patient have a diagnosis of HIV in the last three years?
- ☐ Yes ☐ No Does the patient have a diagnosis of cachexia in the last 365 days?
- ☐ Yes ☐ No Does the patient have a diagnosis of short bowel syndrome in the last three years?

Patient name: ________________________________ Patient ID #: _____________________

Additional for nonpreferred growth hormone products:

☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least one preferred agent within the past 180 days.
If yes, please indicate which agent(s): ____

☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents (at least one) in this class.
If yes, please indicate which agent(s): ____

☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the Texas Medicaid *Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs**.

9. Physician signature

____ _______________________________

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.