

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 844-474-3341.

1. Patient information
2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication
4. Strength
5. Directions
6. Quantity per 30 days

			Specify:
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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.)

<input type="checkbox"/>	<input type="checkbox"/>	Is medication is being provided and billed at the physician's office?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of Growth Hormone Deficiency in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of Idiopathic Short Stature in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of panhypopituitarism in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of SHOX deficiency, Turner syndrome, Noonan syndrome, or Prader-Willi syndrome in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of Chronic Kidney Disease in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a history of renal transplant in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of active malignancy in the last 180 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a history of chemotherapy/radiation in the last 180 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of active proliferative or severe nonproliferative diabetic retinopathy in the last 365 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of HIV in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of cachexia in the last 365 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the patient have a diagnosis of short bowel syndrome in the last three years?
<input type="checkbox"/>	<input type="checkbox"/>	Is the client greater than or equal to (\geq) 1 year of age and weigh greater than or equal to (\geq) 11.5 kg?
<input type="checkbox"/>	<input type="checkbox"/>	Does the client have a diagnosis of obstructive sleep apnea in the last 365 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the client have a history of CPAP or BiPAP in the last 730 days?

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.

Amerigroup members in the Medicaid Rural Service Area and the STAR Kids program are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.

Yes No Does the client have a diagnosis of papilledema in the last 180 days?

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/formulary-search>

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.

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