ADULT (≥18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM

(OptumRx P.O. Box 25184 Santa Ana, CA, 92799 Phone: (800) 310-6826 Fax: (866) 940-7328	_ ○ ₽	United Healthcare Community Plan

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"

			icable testing suppo	rting 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 wou	Id like to utilize a nor	-preferred agent ove	er preferred agent ba	ased on the following
	medical justific	ation:			
	<u> </u>				
*The fo	llowing docun	ciated wasting or cach nentation will be rec		/) s of "HIV- associate	ed wasting or
ca	chexia"				
•		c impedance analysis		XA (dual energy X-ra	ay absorptiometry) or
•	Documentation		/	aseline total body we	ight OR body cell
Membe	er's current AIDS	S/HIV anti-retroviral re	egimen:		
			•	ate, dose, frequency, □ None □ Other (pl	
 ,,					
For ALL indic	ations* – Presc	riber attests that they	have performed all	necessary testing to	ensure there are no
expanding intra	acranial lesions	or tumors prior to init	iating growth hormo	ne therapy 🗌 Yes	🗌 No
I,			haraby attact th	of I have norformed	
testing to ens				hat I have performed	
•				cranial lesions or tu	
•	ure that this m /th hormone th				
•	/th hormone th				
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Please s	select one of the Request is for a Request is for a List indication:	preferred agent non-preferred agent d like to utilize a non-	with a product-spe	ecific indication:	wth hormone based on the following
Member	has a diagnosi	s of HIV-associated v	vasting or cachexia	and is continuing of	growth hormone
therapy •	Member's curre Member has de	ent AIDS/HIV anti-retremonstrated an increa mentation required)	oviral regimen: ase in total body we		
expanding intrac	cranial lesions o	or tumors prior to initia	ating growth hormo	ne therapy 🗌 Yes	
I, testing to ensu initiating growt Prescriber Sigr	re that this me h hormone the		hereby attest the expanding intrac	nat I have perform cranial lesions or	ed all necessary tumors prior to
Please complete	e the following:				
Current		height:	(inches)	weight:	(lbs)
3 month	ns prior:	height:	(inches)	weight:	(lbs)
6 month	ns prior:	height:	(inches)	weight:	(lbs)
Diagnosis of adu *The following	ult growth horm documentatio	N) – Initial Authori one deficiency □ Ye n will be required fo	es No r diagnosis of "ac	-	one deficiency"
		or other applicable te Ider	sting supporting the	e diagnosis	
Please select or	ne of the following	ng:			

- □ Trial and failure of ONE 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 \Box Yes \Box 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

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: _____

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