Reset Form | Print Form

United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

Human Growth Hormone

***Preferred**: Genotropin, Ngenla, Norditropin, Skytrofa, Sogroya*
***Non-Preferred**: Humatrope, Nutropin, Omnitrope, Saizen, Zomacton*
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ___

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ___

Prescriber Fax Number ___ - ___ - ___

Drug: _____ **Quantity:** _____ **Dosage Frequency:** _____

Height: _____ in or _____ cm **Weight:** _____ lbs or _____ kg **BMI:** _____ kg/m^2

Date last seen by the prescribing endocrinologist: _____

Diagnosis: (Please check all that apply and submit progress notes.)

☐ **Documented growth hormone (GH) deficiency (treated by a board certified endocrinologists)**

- ☐ Lowered growth hormone levels secondary to the normal aging process, obesity or depression?
- ☐ Growth hormone deficiency due to pituitary disease, hypothalamic disease, trauma, surgery, radiation therapy, acquisition as an adult or diagnosis during childhood?
- ☐ Acquired Immunodeficiency Syndrome (AIDS) wasting or cachexia? (Please submit Human Growth for HIV Wasting in Adults (Serostim) Form)
- ☐ **Other:** _____ **Diagnosis Code:** _____

☐ **Treatment of short bowel syndrome in patient receiving specialized nutrition support (Zorbtive®)**

- ☐ **Date Therapy Initiated:** _____ (Authorization will consist of one four-week course of therapy.)

United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

Human Growth Hormone

***Preferred**: Genotropin, Ngenla, Norditropin, Skytrofa, Sogroya*
***Non-Preferred**: Humatrope, Nutropin, Omnitrope, Saizen, Zomacton*
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Full Name

Date of Birth (MM/DD/YYYY)

Fill in all related test results below. Medical records and all related official lab reports (dated within the past 6 months) must be submitted. *(If the request is for continuation of therapy in a child, the growth information below must be provided.)*

Growth Velocity: _____ (SD) and _____ (cm/year) **Bone Age:** _____ (year) **Height:** _____ (%)

Growth Plate: ☐ Open or ☐ Closed

Mid-Parental Height: _____ [(father's height + mother's height) ÷ 2, plus 2.5 inches (male) or minus 2.5 inches (female)]

Providers must correct for Thyroid Stimulating Hormone (TSH) deficiency prior to conducting a stimulation test:

TSH: _____ mU/L **Normal Range:** _____ **Date:** _____

Stimulation Testing: *(Copies of official test results must be submitted)* The preferred stimulation test is the Insulin Tolerance Test (ITT). Levodopa and Clonidine are not adequate agents for adult testing.

Test 1: type _____ **Peak GH Value:** _____ ng/mL **Standard Peak:** _____ ng/mL **Date:** _____

Test 2: type _____ **Peak GH Value:** _____ ng/mL **Standard Peak:** _____ ng/mL **Date:** _____

Previous IGF-1 (if applicable) _____ ng/mL **Normal range (for age):** _____ **Date:** _____

Recent IGF-1: _____ ng/mL **Normal range (for age):** _____ **Date:** _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025