Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Growth Hormones
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information					
☐ **Genotropin®**	☐ **Norditropin Flexpro®**	☐ **Norditropin®**	☐ **Nutropin AQ®**	☐ **Humatrope®**	
☐ **Omnitrope®**	☐ Zomacton®	☐ **Serostim®**	☐ **Skytrofa®**	☐ **Sogroya®**	☐ **Ngenla®**
Other, please specify:					
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐Yes ☐ No		ICD-10 Code:	Diagnosis:		
What medication(s) have been tried and failed for diagnosis? (please specify):					
Directions for Use:	Strength:		Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:		

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information (select one of the following diagnoses)					
Panhypopituitarism:	☐ Cachexia, pituitary	☐ Necrosis of pituitary (postpartum)	☐ Pituitary insufficiency NOS	☐ Sheehan's syndrome	☐ Simmond's disease
Pituitary dwarfism:	☐ Isolated deficiency of (human) growth hormone [HGH]	☐ Lorain-Levi dwarfism)			
Endocrine disorders – Other specified endocrine disorders:	☐ Pineal gland dysfunction	☐ Progeria	☐ Werner's syndrome		
Intermediate sex and pseudohermaphroditism:	☐ Gynandrism	☐ Hermaphroditism	☐ Ovotestis	☐ Pseudohermaphroditism (male, female)	☐ Pure gonadal dysgenesis
Gonadal dysgenesis:	☐ Turner's Syndrome (female only)	☐ XO syndrome	☐ Ovarian dysgenesis		
☐ **Prader-Willi Syndrome (Genotropin and**	☐ **CKD – stage 1, 2 or 3 (Nutropin only)**	☐ **CKD – stage 4 or 5**	☐ **SHOX (Humatrope only)**		

Norditropin Flexpro only)			

☐ **Idiopathic Short Stature (Requires submission of medical records)**

Growth Hormone Stimulation Testing

Pituitary Dwarfism:	☐ Member failed two kinds of growth hormone stimulation testing (required for all members)	☐ Member is an adolescent with closed epiphyseal growth plates or an adult	☐ Testing was done after growth hormone therapy has been suspended at least 3 months

Are the kinds of stimulation tests performed, the result (lab value), reference range and date attached with the request?	☐ Yes	☐ No

Papilledema:	☐ Provider is aware of the risk of intracranial hypertension and the role of fundoscopic examination to assess and monitor for papilledema.

Bone Age X-Rays (required regardless of diagnosis, but not for adults; x-ray does not have to be performed within a specific time frame)

For pediatric members: is the bone x-ray report attached (unless the prescriber is a pediatric endocrinologist)?	☐ Yes	☐ No
For adolescent members (13 to 19 years of age): is the bone x-ray report attached (unless the prescriber is a pediatric endocrinologist)?	☐ Yes	☐ No
For adolescent members (13 to 19 years of age): have the epiphyseal growth plates closed?	☐ Yes	☐ No

NOTE: Requests that do not meet clinical criteria will require further review and must include the patient's diagnosis including ICD-10, if available. Growth charts should be provided, if available, at time of review (ensure that the correct chart is being submitted based on the patient's age – for example., 0–3 vs 2–20) in addition to documentation of small for gestational age at birth, if appropriate.

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.