PRIOR AUTHORIZATION REQUEST FORM
Growth Hormone Agents

DATE OF REQUEST:________________

MEMBER INFORMATION

NAME ____________________________________

ID# ______________________________________

BIRTHDATE ________________

☑ PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PRESCRIBING PHYSICIAN INFORMATION

NAME ____

NPI # ____

ADDRESS ____

____

PHONE #_________________FAX #___________________

CONTACT NAME ____________________________________

PROVIDER SIGNATURE ______________________________

Drug Requested: ________________________________ **Dose/frequency:** ___________________________________

Diagnosis: _________________________________

ICD-10 code: _________________________________

□ Pediatric Growth Hormone Deficiency
□ Adult Growth Hormone Deficiency
□ Prader-Willi Syndrome
□ Turner Syndrome
□ Other (identify and provide clinical documentation to support request)
____
____

Initial
Height: _______cm Weight: ______kg Date:______________
Growth hormone level (attach laboratory values)
Predicted adult height _______ cm
Mean parental height ________cm
Bone age _________ Date: ______________
Growth velocity (attach growth chart)

Extension
Date GH therapy initiated: _____________
Height: _____cm Date:____________
Growth velocity (attach growth chart)
Bone age _________ Date: ______________

Diagnosis:

☐ AIDS wasting syndrome (provide laboratory data including HIV RNA levels and chart notes identifying HAART therapy, Karnofsky score, and nutritional assessment)
□ Short Bowel Syndrome on TPN (please provide chart notes)
□ Other _______________________________

Initial
Previous weight: _______kg Date:_______________
Current weight: ________kg Date:_______________
HIV viral load: __________copies/mL

Extension
Date GH therapy initiated: _____________
Current Weight: _______kg Date:_______________

Authorizations will be approved for up to 12 months of therapy at FDA approved dosing and frequency parameters

☑ **PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. *REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.*

*Refer to the MVP Formulary at **www.mvphealthcare.com** for those drugs that require prior authorization or are subject to quantity limits or step therapy.*

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
(HMO, EPO/PPO, Exchange, Medicaid, Child Health Plus, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)

Effective February 2016