INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
ADULT (≥ 18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION (PA) REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 866-930-0019

CareSource RxInnovations

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent ☐ Urgent ☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Member's CareSource ID	Member's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Member's Name	Prescriber's Name
Prescriber's Indiana License Number	Specialty
Prescriber's National Provider Identifier	Office Contact
Prescriber Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber Address	Date(s) of Service Start Date
Diagnosis	Diagnosis Code

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 the following:

- Member has reached adult height
- Member stopped growth hormone therapy for at least one 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 a preferred agent, based on the following medical justification:

_____

_____

_____

SOMATROPIN AGENTS – Initial Authorization (continued)

Please select one of the following (continued):

☐ Member has a diagnosis of adult growth hormone deficiency

The following documentation will be required for diagnosis of "growth hormone deficiency:"

- Biochemical evidence or other applicable testing supporting 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 would like to utilize a non-preferred agent over a preferred agent, based on the following medical justification:

_____

_____

_____

☐ Member has a diagnosis of HIV-associated wasting or cachexia (Serostim only)

The following documentation will be required for diagnosis of "HIV-associated wasting or cachexia:"

- Quantitative measurement of lean body mass using DEXA (dual energy X-ray absorptiometry) or BIA (bioelectric impedance analysis)
- Documentation of involuntary weight loss of > 10% of baseline total body weight OR body cell mass < 30% for initial approval

Member's current AIDS/HIV anti-retroviral regimen:

_____

Member has tried and failed one of the following (include trial date, dose, frequency, duration and reason for failure in lines below selections):

☐ Dronabinol

☐ Megestrol

☐ Anabolic Steroids

☐ Other (please explain)

☐ None

_____

_____

_____

For ALL indications – 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?

□ Yes □ No

I, _____, hereby attest that I have performed all necessary testing to ensure this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: _____ Date: _____

SOMATROPIN AGENTS – Initial Authorization (continued)

Please complete the following:

Current:	height: _____ (inches)	weight: _____ (lbs)
3 months prior:	height: _____ (inches)	weight: _____ (lbs)
6 months prior:	height: _____ (inches)	weight: _____ (lbs)

SOMATROPIN AGENTS – Reauthorization

Please select one of the following:

☐ Member has previously been transitioned from pediatric 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 a preferred agent, based on the following medical justification:
  _____
  _____
  _____

☐ Member has a diagnosis of adult growth hormone deficiency and is continuing growth hormone
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 a preferred agent, based on the following medical justification:
  _____
  _____
  _____

☐ Member has a diagnosis of HIV-associated wasting or cachexia and is continuing growth hormone therapy
- Member's current AIDS/HIV anti-retroviral regimen:
  _____
- Member has demonstrated an increase in total body weight or lean body mass from treatment baseline **(documentation required)**

For ALL indications – 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?
□ Yes □ No

I, _____, hereby attest that I have performed all necessary testing to ensure this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: _____ Date: _____

SOMATROPIN AGENTS – Reauthorization (continued)

Please complete the following:

Current:	height: _____ (inches)	weight: _____ (lbs)
3 months prior:	height: _____ (inches)	weight: _____ (lbs)
6 months prior:	height: _____ (inches)	weight: _____ (lbs)

SOGROYA (SOMAPACITAN) – Initial Authorization

Diagnosis of adult hormone deficiency? ■ Yes □ No

The following documentation will be required for diagnosis of "growth hormone deficiency:"

- Biochemical evidence or other applicable testing supporting the diagnosis

Member is 18 years of age or older? □ Yes □ No

Please select one of the following:

☐ Trial and failure of ONE preferred somatropin products
List indication: _____

☐ Prescriber would like to utilize a Sogroya (somapacitan) over ALL preferred somatropin agents based on the following medical justification:
_____
_____
_____

For ALL indications – 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?
□ Yes □ No

I, _____, hereby attest that I have performed all necessary testing to ensure this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: _____ Date: _____

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?
☐ Yes ☐ 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: _____ Date: _____