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

Patient's CareSource # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's Indiana License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's National Provider Identifier (NPI) # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return 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 of 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 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"**

- 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 preferred agent based on the following medical justification:

_____

_____

☐ 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): ☐ Dronabinol ☐ Megestrol ☐ Anabolic Steroids ☐ None ☐ Other (please explain)

_____

_____

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 that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: _____

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 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 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 that this member does not have expanding intracranial lesions or tumors prior to initiating growth hormone therapy.

Prescriber Signature: _____

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 growth hormone deficiency ☐ Yes ☐ No

***The following documentation will be required for diagnosis of "adult 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 ALL 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 ☐ 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: _____

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: _____

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