

~Growth Stimulating Agents ~

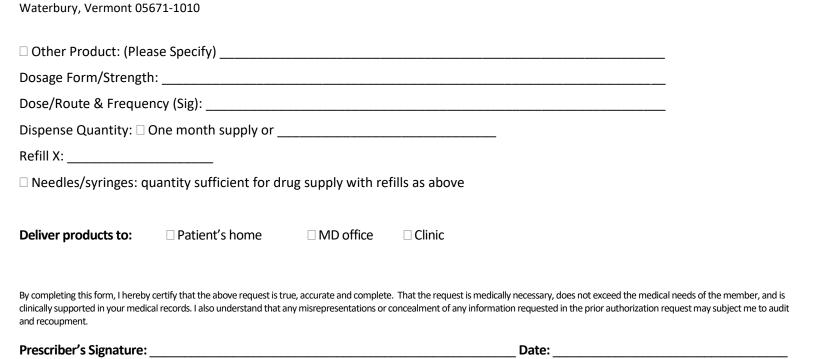
Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:	Beneficiary:		
Name:Physician NPI:	Name:		
	Medicaid ID#: Date of Birth: Patient's Phone: Pharmacy Name Pharmacy NPI: Pharmacy Phone: Pharmacy Phone: Pharmacy Phone:		
		Contact Person at Office:	
		Patient Diagnosis:	
		Requested DVHA PREFERRED Growth Stimulating	; Agent:
			□ Norditropin® □ Genotropin®
Growth Hormone Stimulation Test #1:		Results:	
Growth Hormone Stimulation Test #2:	Results:		
Patient's Height: Patient's Bone Age: Patient's Chronological Age:			
Growth Velocity: IGF-	1 results:		
□ Humatrope® □ Omnitrope® □ Nutropin® □ Saizen® □ Skytrofa® □ Zomacton® Medical justification: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			
Request is for a 'SPECIALIZED INDICATION' produ	ct: (Criteria in PDL)		
□ Inci	relex® Serostim® Zorbtive®		
Other information/Prescribers Comments:			
Product Name:			
☐ Norditropin® FlexPro: ☐ 5 mg/1.5 ml ☐ 10 mg	g/1.5 ml □ 15 mg/1.5 ml □ 30 mg/3 ml		
\Box Genotropin cartridge (with preservative): $\ \Box$ 5 r	ng (green tip) 🗆 12mg (purple tip)		
☐ Genotropin Miniquick cartridge (without preser	vative): \square 0.2 mg \square 0.4 mg \square 0.6 mg \square 0.8 mg \square 1 mg		
	\square 1.2 mg \square 1.4 mg \square 1.6 mg \square 1.8 mg \square 2 mg		







Department of Vermont Health Access

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