

## ~Growth Stimulating Agents ~

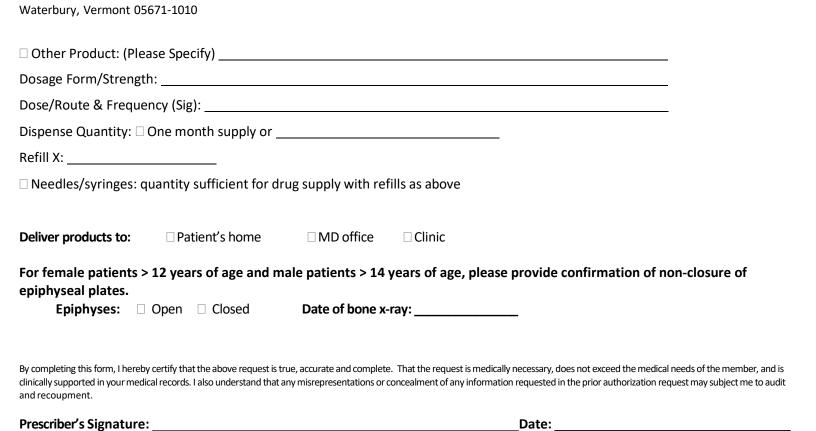
## **Prior Authorization Request Form**

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:	Beneticiary:	
Name:Physician NPI:	Name: Medicaid ID#:	
Specialty:	_ Date of Birth:Sex:	-
Phone#:		_
		_
Contact Person at Office:	Pharmacy Phone:Pharmacy Fax:	_
Patient Diagnosis:		
Requested DVHA PREFERRED Growth Stimulati	ing 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:IG	GF-1 results:	
Please explain the medical necessity for a 'NON    Humatrope®   Omnitrope®	I-PREFERRED' product:  □ Nutropin® AQ □ Saizen® □ Sogroya® □ Skytrofa® □ Zomacton®	
Medical justification:		
Request is for a 'SPECIALIZED INDICATION' proc	duct: (Criteria in PDL)	
·	ncrelex®   Serostim®   Zorbtive®	
Other information/Prescribers Comments:		
Product Name:		
$\square$ Norditropin <sup>®</sup> FlexPro: $\square$ 5 mg/1.5 ml $\square$ 10 r	mg/1.5 ml $\Box$ 15 mg/1.5 ml $\Box$ 30 mg/3 ml	
$\Box$ Genotropin cartridge (with preservative): $\Box$	5 mg (green tip) 🗆 12mg (purple tip)	
☐ Genotropin Miniquick cartridge (without pres	servative): $\Box$ 0.2 mg $\Box$ 0.4 mg $\Box$ 0.6 mg $\Box$ 0.8 mg $\Box$ 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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