VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~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:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

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: _____

Please explain the medical necessity for a 'NON-PREFERRED' product:

☐ Humatrope® ☐ Omnitrope® ☐ Nutropin® AQ ☐ Saizen® ☐ Sogroya® ☐ Skytrofa® ☐ Zomacton® ☐ Ngenla™

Medical justification: _____

_____

Request is for a 'SPECIALIZED INDICATION' product: (Criteria in PDL)

☐ Increlex® ☐ Serostim® ☐ Zorbtive®

Other information/Prescribers Comments: _____

_____

Product Name:

☐ Norditropin® FlexPro: ☐ 5 mg/1.5 ml ☐ 10 mg/1.5 ml ☐ 15 mg/1.5 ml ☐ 30 mg/3 ml

☐ Genotropin cartridge (with preservative): ☐ 5 mg (green tip) ☐ 12mg (purple tip)

☐ Genotropin Miniquick cartridge (without preservative): ☐ 0.2 mg ☐ 0.4 mg ☐ 0.6 mg ☐ 0.8 mg ☐ 1 mg
☐ 1.2 mg ☐ 1.4 mg ☐ 1.6 mg ☐ 1.8 mg ☐ 2 mg

CHANGE HEALTHCARE

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☐ Other Product: (Please Specify) _____

Dosage Form/Strength: _____

Dose/Route & Frequency (Sig): _____

Dispense Quantity: ☐ One month supply or _____

Refill X: _____

☐ Needles/syringes: quantity sufficient for drug supply with refills as above

Deliver products to: ☐Patient's home ☐MD office ☐Clinic

For female patients > 12 years of age and male patients > 14 years of age, please provide confirmation of non-closure of epiphyseal plates.

Epiphyses: ☐ Open ☐ Closed **Date of bone x-ray:** _____

By completing this fonn, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records.I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber's Signature: _____ **Date:** _____

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