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® ☐ Saizen® ☐ Zomacton®

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

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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

By completing this form, 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:** ______________________________