ADULT (≥18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM

Good	<i>OptumRx</i> P.O. Box 25184 Santa Ana, CA, 92799 Phone: (800) 310-6826 Fax: (866) 940-7328	Optum Rx [®] ↓ United Healthcare Community Plan
Today's Date		Community Plan

Note: This form must be completed by the prescribing provider.

All sections must be completed or the request will be returned

Patient's Medicaid #	Date of Birth
Patient's Name	Prescriber's Name
Prescriber's IN License #	Specialty
Prescriber's NPI #	Prescriber's Signature
Return Fax #	Return Phone #
Check box if requesting retro-active PA	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

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 1 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 diagnosi			• " · · ·	
*The following docum			-	ne deficiency"
		licable testing suppor	ting the diagnosis	
	Please select one of the following: Request is for a preferred agent 			
•		nt with a product-spec	cific indication:	
List indication:				
		n-preferred agent ove	er preferred agent ba	used on the following
medical justifica		r protonoù agont ore	n protonioù agont ba	lood on the renorming
Diagnosis of HIV-assoc	-	· · ·		
*The following docum cachexia"	entation will be red	quired for diagnosis	s of "HIV- associate	ed wasting or
	easurement of lean l c impedance analysis		XA (dual energy X-ra	ay absorptiometry) or
Documentation	of involuntary weigh	ht loss of >10% of ba	seline total body wei	ight OR body cell
mass <30% for	⁻ initial approval			
Member's current AIDS	Member's current AIDS/HIV anti-retroviral regimen:			
Member has tried and failed one of the following (include trial date, dose, frequency, duration, reason				
	for failure): Dronabinol Megestrol Anabolic Steroids None Other (please explain)			
For ALL indications* – Presci	•	•		
expanding intracranial lesions	or lumors prior to init	lialing growth normor	ie therapy 🗀 Yes	
1		hereby attest th	at I have performed	all necessary
testing to ensure that this me	ember does not hav			
initiating growth hormone th		J		
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)
• -	J	\ /	J	\ /

SOMATRO	PIN AGENTS	– Reauthori	zation			
Member Please	e select one of th Request is for a Request is for a List indication:	been transition e following: a preferred ager a non-preferred ld like to utilize a	nt agent with a	a product-spe		y nt based on the following
Please	e select one of th Request is for a Request is for a List indication:	e following: a preferred ager a non-preferred	nt agent with a	a product-spe		rowth hormone
Membe therap	medical justifica	ation: s of HIV-associ ent AIDS/HIV ar	ated wasting	g or cachexia regimen:	and is continuin	g growth hormone
expanding intra	ations* – Presci acranial lesions o	or tumors prior t	t they have to initiating g	rowth hormo	ne therapy 🗌 `` nat I have perfor	ng to ensure there are no Yes 🔲 No Trmed all necessary for tumors prior to
Prescriber Sig	vth hormone the					
Please comple	ete the following:					
Curre	nt:	height:		(inches)	weight:	(lbs)
3 mon	ths prior:	height:		_(inches)	weight:	(lbs)
6 mon	ths 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 \Box Yes \Box 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 \Box Yes \Box No			
I,hereby attest that I have performed all necessary			
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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