AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Growth Hormones

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:	Patient name:	
Patient address:		DOB:
Provider NPI:	Prescriber name:	Phone:
Prescriber address:		Fax:
Pharmacy name:		
Address:		Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI:	Pharmacy fax:	NDC:

Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent(s). All of the following criteria must be met for approval for prescribing of growth hormones: 1. Standard deviation of 2.0 or more below mean height for chronological age, 2. No intracranial lesion or tumor diagnosed by MRI, 3. Growth rate below five centimeters per year, 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter. Stimuli testing will not be required for the following diagnoses: Turner syndrome, chronic renal failure and HIV/AIDS. 5. Annual bone age testing is required for a diagnosis of growth hormone deficiency. Bone age must be 14 to 15 years or less in females and 15 to 16 years or less in males, 6. Epiphyses open. Prior authorization will be granted for 12-month periods per member as needed. The following FDA approved indication for growth hormone therapy is considered not medically necessary and requests will be denied; Idiopathic Short Stature (ISS) and Small for Gestational Age (SGA). If the request is for Zorbtive® [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred: ☐ Norditropin ☐ Nutropin AQ Pen ☐ Nutropin AQ NuSpin

Non-Preferred: ☐ Genotropin ☐ Humatrope ☐ Omnitrope ☐ Saizen ☐ Tev-Tropin ☐ Zorbtive

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis:

Previous Growth Hormone Therapy (include drug name(s), strength, and exact date ranges):

Number of vials per month:		Estimated length of therapy:	
Bone Age:		Date of Bone Age Test:	Epiphyses open? ☐ Yes ☐ No
Height:	Weight:	Height percentile at time of diagnosis:	Weight percentile:
Is standard deviation 2.0 or more below mean height for chronological age or less than fifth percentile? ☐ Yes ☐ No			
MRI diagnosis:			Date:
Growth rate per year:			

AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Growth Hormones

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Pertinent Medical History including growth pattern, diagnostic test, treatment plan, and response so far:

Please provide 2 stimuli tests and results:

Reason for use of Non-Preferred drug requiring prior approval: _____

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: in evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's medicaid eligibility card and, if necessary by contact with the county department of human services, that the member continues to be eligible for medicaid.