INDIANA HEALTH COVERAGE PROGRAMS (IHCP) ADULT (≥18 YEARS OF AGE) GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM



MDwise Fax to: (858) 790-7100 c/o MedImpact Healthcare Systems, Inc. Attn: Prior Authorization Department 10181 Scripps Gateway Court, San Diego, CA 92131 Phone: (800) 788-2949



| Constant | | | Phone: | (800) 788-2949 | | | A McLare |
|---|---|------------------|--------------------|---|-------------|---------------|----------|
| Today's Date | | | | | | | |
| Note: This form must be comple | eted by t | he pres | scribing | g provider. | | | |
| | ons mu | st be co | mplete | ed or the request v | will be ret | urned** | |
| Patient's Medicaid # | | | | Date of Birth | | // | |
| Patient's Name | | | | Prescriber's Name | | | |
| Prescriber's IN License # | | | | Specialty | | | |
| Prescriber's NPI# | | | | Prescriber's Signat | ture | | |
| Return Fax # | | - | | Return Phone # | | - | - |
| Check box if requesting retro-active | PA | | | Date(s) of service retro-active eligibili | | | |
| Requested Medication and Str | ength | | De | osage | 1 | reatment Du | ıration |
| SOMATROPIN AGENTS – Initial Please select one of the followi Member is transitioning from | ng: om pedia | | vth horn | mone therapy | | | |
| for continued ther • Prescriber has de | hed aduligrowth he apy termined old receivollowing: | ormone I that me | therapy ember v | y for at least 1 mon will experience grow efit from continued o | vth hormo | ne deficiency | into |
| ☐ Request is for a ne | on-prefer | red age | nt with | a product-specific i | ndication: | | |

RXP0016 (4/23)

| | | | | hormone deficien | | ,, | |
|--------|--------------|-------------------------------|----------------------|----------------------------------|---------------|--------------------|---------------------------|
| | | _ | | | _ | 'growth ho | rmone deficiency" |
| | | iochemical evelect one of the | | g supporting the dia | agnosis | | |
| | | | a preferred agent | ł | | | |
| | | • | | agent with a produc | ct-specific | indication: | |
| | | • | • | | • | | |
| | ☐ Pr | escriber wou | ld like to utilize a | non-preferred age | ent over pre | eferred age | nt based on the following |
| | m | edical rationa | ile: | | | | |
| | _ | | | | | | |
| | _ | | | | | | |
| | Diamaria | af alaant laass | | de iti e a cara le d | | | |
| | _ | | el syndrome (Zor | rollive only) required for diag | anosis of ' | "short how | el syndrome" |
| | | _ | | diagnosis of short | | | ci syndronic |
| | | | | nt is receiving spec | | | port |
| | Diagnosis | of HIV-assoc | ciated wasting or | cachexia (Serostir | n onlv) | | |
| | | | | | | "HIV- asso | ciated wasting or |
| | cache | | | | | | |
| | | | | | ng DEXA (d | dual energy | X-ray absorptiometry) or |
| | | , | c impedance ana | , | of baselir | ne total body | y weight OR body cell |
| | | | r initial approval | 0191111000 01 2 10 7 | , or bacom | io total body | worght of t body con |
| | Manahawia | aumant AIDC | 2/1111/ anti vatua i | | | | |
| | Member's | current AIDS | 5/HTV anti-retrovii | rai regimen: | | | |
| | Member h | as tried and | failed one of the | following (include | trial date, c | Jose, freque | ency, duration, reason |
| | for failure) | : Dronal | binol Megestro | ol Anabolic Ste | roids 🗌 No | one \square Othe | er (please explain) |
| | | | | | | | |
| | | | | | | | |
| Please | complete t | the following: | | | | | |
| | | 3 | | | | | |
| | Current: | | height: | (inche | es) we | ight: | (lbs) |
| | 3 months | prior: | height: | (inche | es) we | eight: | (lbs) |
| | 6 months | nrior: | hoight: | (inche | 00) W6 | sight: | (lbs) |
| | 6 months | prior. | neignt. | (IIICITE | 35) WE | igrit | (lbs) |
| | | | | | | | |
| SOMA | TROPIN A | GENTS – Re | authorization | | | | |
| Please | select on | e of the follo | owing: | | | | |
| | Member h | as previously | been transitione | ed from pediatric gr | rowth horm | none therapy | у |
| | | elect one of th | _ | | | | |
| | | • | a preferred agent | | | | |
| | | • | • | agent with a produc | | | |
| | | ist indication: | | | | | |
| | | | | non-preferred age | ent over pre | eferred agei | nt based on the following |
| | m | edical rationa | ıle: | | | | |
| | | | | | | | |
| | _ | | | | | | |
| | _ | | | | | | |
| | _ | as a diagnos | is of adult growth | hormone deficien | cv and is c | ontinuina a | rowth hormone |

| ☐ Request is f | for a preferred agent | | | | | |
|---|---|--|--|------------------------|--|--|
| ☐ Request is f | Request is for a non-preferred agent with a product-specific indication: | | | | | |
| List indication | List indication: | | | | | |
| ☐ Prescriber w | vould like to utilize a no | on-preferred agent over | er preferred agent | based on the following | | |
| medical ratio | onale: | | | | | |
| | | | | | | |
| | | | | | | |
| ☐ Member has a diagr | nosis of short bowel sy | ndrome and is continu | ing to receive sne | acialized nutritional | | |
| support (document | • | naronie ana is contine | allig to receive spe | olalized Hathtional | | |
| | nosis of HIV-associated | d wasting or cachexia | and is continuing | growth hormone | | |
| therapy | | 9 | 3 | 9 | | |
| | current AIDS/HIV anti-re | etroviral regimen: | | | | |
| Member has | s demonstrated an inci | rease in total body we | eight or lean body | mass from treatment | | |
| baseline (de | ocumentation require | (d) | | | | |
| Please complete the following | na: | | | | | |
| r lease complete the following | rig. | | | | | |
| Current: | height: | (inches) | weight: | (lbs) | | |
| 3 months prior: | height: | (inches) | weight: | (lbs) | | |
| - | | , , | | , , | | |
| 6 months prior: | height: | (inches) | weight: | (lbs) | | |
| | | | | | | |
| | | | | | | |
| SOGROYA (SOMAPACITA | AN) – Initial Authoriza | tion | | | | |
| Diagnosis of adult growth he | , | | | | | |
| *The following documenta | • | | owth hormone d | eficiency" | | |
| Biochemical eviden | nce or testing supporting | g the diagnosis | | | | |
| Member is 18 years of age | or older | 0 | | | | |
| , , | | | | | | |
| Please select one of the foll | lowing: | | | | | |
| | of ALL preferred soma | tropin products | | | | |
| List products tria | | | | | | |
| | d like to utilize a Sogro | us (compragitary) aus | er ALL preferred so | omatropin agents | | |
| | | | • | 1 3 | | |
| | llowing medical rationa | | · | | | |
| | llowing medical rationa | | | | | |
| | ellowing medical rationa | | | | | |
| | ollowing medical rations | | · | | | |
| | | ale: | | | | |
| based on the fo | have performed all ned | cessary testing to ens | ure there are no e | | | |
| based on the fo | have performed all ned | cessary testing to enset therapy \(\square \text{ Yes } \square | ure there are no e | xpanding intracranial | | |
| Prescriber attests that they lesions or tumors prior to ini | have performed all neo | cessary testing to ensetherapy Yes hereby attest th | ure there are no e No at I have perforn | xpanding intracranial | | |
| Prescriber attests that they lesions or tumors prior to init. | have performed all neo itiating growth hormone s member does not ha | cessary testing to ensetherapy Yes hereby attest th | ure there are no e No at I have perforn | xpanding intracranial | | |
| Prescriber attests that they lesions or tumors prior to ini | have performed all neo itiating growth hormone s member does not ha | cessary testing to ensetherapy Yes hereby attest th | ure there are no e No at I have perforn | xpanding intracranial | | |

| 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 \Box Yes \Box 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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