



Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

Aetna Better Health®

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Growth Hormones Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information						
Member Name (first & last):		Date of Birth:		Gender:		Height:
				<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Member ID:		City:		State:		Weight:
Prescribing Provider Information						
Provider Name (first & last):		Specialty:		NPI#		DEA#
Office Address:		City:		State:		Zip Code:
Office Contact:			Office Phone		Office Fax:	
Dispensing Pharmacy Information						
Pharmacy Name:			Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information						
<input type="checkbox"/> Genotropin®	<input type="checkbox"/> Norditropin Flexpro®	<input type="checkbox"/> Norditropin®	<input type="checkbox"/> Nutropin AQ®	<input type="checkbox"/> Humatrope®		
<input type="checkbox"/> Omnitrope®	<input type="checkbox"/> Zomacton®	<input type="checkbox"/> Serostim®	<input type="checkbox"/> Skytrofa®	<input type="checkbox"/> Sogroya®	<input type="checkbox"/> Ngenia®	
Other, please specify:						
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes No				ICD-10 Code:		Diagnosis:
What medication(s) have been tried and failed for diagnosis? (please specify):						
Directions for Use:		Strength:			Dosage Form:	
		Quantity:		Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review						
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____			
Clinical Information (select one of the following diagnoses)						
Panhypopituitarism/ Hypopituitarism:	<input type="checkbox"/> Cachexia, pituitary	<input type="checkbox"/> Necrosis of pituitary (postpartum)	<input type="checkbox"/> Pituitary insufficiency NOS	<input type="checkbox"/> Sheehan's syndrome	<input type="checkbox"/> Simmond's disease	<input type="checkbox"/> Growth Hormone Deficiency
Pituitary dwarfism:	<input type="checkbox"/> Isolated deficiency of (human) growth hormone [HGH]			<input type="checkbox"/> Lorain-Levi dwarfism)		
Endocrine disorders – Other specified endocrine disorders:	<input type="checkbox"/> Pineal gland dysfunction		<input type="checkbox"/> Progeria		<input type="checkbox"/> Werner's syndrome	
Intermediate sex and pseudohermaphroditism:	<input type="checkbox"/> Gynandrim	<input type="checkbox"/> Hermaphroditism	<input type="checkbox"/> Ovotestis	<input type="checkbox"/> Pseudohermap hroditism (male, female)	<input type="checkbox"/> Pure gonadal dysgenesis	
Gonadal dysgenesis:	<input type="checkbox"/> Turner's Syndrome (female only)		<input type="checkbox"/> XO syndrome		<input type="checkbox"/> Ovarian dysgenesis	
<input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> CKD – stage 1, 2 or 3		<input type="checkbox"/> CKD – stage 4 or 5		<input type="checkbox"/> SHOX (Humatrope only)	

(Genotropin and Norditropin Flexpro only)		(Nutropin only)				
<input type="checkbox"/> Idiopathic Short Stature (Requires submission of medical records)						
Growth Hormone Stimulation Testing						
Pituitary Dwarfism:	<input type="checkbox"/> Member failed two kinds of growth hormone stimulation testing (required for all members)	<input type="checkbox"/> Member is an adolescent with closed epiphyseal growth plates or an adult	<input type="checkbox"/> Testing was done after growth hormone therapy has been suspended at least 3 months			
Are the kinds of stimulation tests performed, the result (lab value), reference range and date attached with the request?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
Papilledema:	<input type="checkbox"/> Provider is aware of the risk of intracranial hypertension and the role of fundoscopic examination to assess and monitor for papilledema.					
Bone Age X-Rays (required regardless of diagnosis, but not for adults; x-ray does not have to be performed within a specific time frame)						
For pediatric members: is the bone x-ray report attached (unless the prescriber is a pediatric endocrinologist)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
For adolescent members (13 to 19 years of age): is the bone x-ray report attached (unless the prescriber is a pediatric endocrinologist)?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
For adolescent members (13 to 19 years of age): have the epiphyseal growth plates closed?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
NOTE: Requests that do not meet clinical criteria will require further review and must include the patient's diagnosis including ICD-10, if available. Growth charts should be provided, if available, at time of review (ensure that the correct chart is being submitted based on the patient's age – for example., 0–3 vs 2–20) in addition to documentation of small for gestational age at birth, if appropriate.						
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records						

Signature affirms that information given on this form is true and accurate and reflects office notes.	
Prescribing Provider's Signature: _____	Date: _____

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Office notes, labs, and medical testing relevant to the request that show medical justification are required
Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.