

FLORIDA MEDICAID PRIOR AUTHORIZATION

Human Growth Hormone

Preferred (with maximum age limit of 16 years): Genotropin, Norditropin **Non-Preferred**: Humatrope, Nutropin, Omnitrope, Saizen, Skytrofa, Zomacton **Note: Form must be completed in full. An incomplete form may be returned.**

Recipie	ent's l	Med	icaio	d ID	#						Da	ate	of	Bir	th (MM/	<u>DD</u>	/Y)	<u> </u>)											
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Recipient's Full Name			
Date of Birth (MM/DD/YYYY)			
Fill in all related test results b must be submitted. (If the requ			dated within the past 6 months) ation below must be provided.)
Growth Velocity:	(SD) and (cm/year)	Bone Age: (year)	Height:(%)
	or Closed		
Mid-Parental Height:	[(father's height + mothe	er's height) ÷ 2, plus 2.5 inches (male) or minus 2.5 inches (female)]
Providers must correct for Th	yroid Stimulating Hormone	(TSH) deficiency prior to conc	lucting a stimulation test:
TSH:	mU/L Normal Range:		Date:
TSH: Stimulation Testing: (Copies o Test (ITT). Levodopa and Clonic	f official test results must be s	ubmitted) The preferred stimula	
Stimulation Testing: <i>(Copies o</i> Test (ITT). Levodopa and Cloni	f official test results must be s dine are not adequate agents	ubmitted) The preferred stimula	tion test is the Insulin Tolerance
Stimulation Testing: (Copies o Test (ITT). Levodopa and Clonic Test 1: type	f official test results must be s dine are not adequate agents Peak GH Value:	<i>submitted)</i> The preferred stimula for adult testing.	tion test is the Insulin Tolerance
Stimulation Testing: (Copies o Test (ITT). Levodopa and Clonic Test 1: type	f official test results must be s dine are not adequate agents Peak GH Value: Peak GH Value:	<i>submitted)</i> The preferred stimula for adult testing. ng / ml Standard Peak:	tion test is the Insulin Tolerance
Stimulation Testing: (Copies of Test (ITT). Test 1: type Test 2: type	f official test results must be s dine are not adequate agents Peak GH Value: Peak GH Value: ng / ml Normal	ubmitted) The preferred stimula for adult testing. ng / ml Standard Peak: ng / ml Standard Peak:	tion test is the Insulin Toleranceng / ml Date:ng / ml Date:

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328 Pharmacy PA Call Center: 1-855-258-1593 **Confidentiality Notice:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.