UnitedHealthcare Community Plan

24 HOURS – URGENT

Prior Authorization Request Form - Growth Hormones

Please complete this form and **fax to: 866-940-7328.** If you questions, please call **800-310-6826.** Thank you.

Section A - Patient Information		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	ZIP code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **new** □ or a **continuation of therapy** □? If so, start date:_____

Is this patient currently hospitalized**?** □**Yes** □ **No**

Section B - Physician Information				
First Name:		Last Name:		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				
Medication:		**Strength:**		
Directions for use:				
Diagnosis (Please be specific & provide as much information as possible)**:**		**ICD-10 code:**		
Prescribed dose:		**Frequency of administration**		

For ALL Requests:

Has the member had **one** of the following diagnoses within the last **365 days**? (Check Answer)

□ **Short Stature** □ **Renal Failure** □ **Turner's Syndrome** □ **Other, List diagnosis**: _____

Has the member had a diagnosis of **Down's or Fanconi syndrome** within the last **365 days**? □Yes □ No

Has the member had a diagnosis of **active malignancy** within the last **180 days**? □Yes □ No

Has the member ad a history of **chemotherapy/radiation (CPTs)** within the last **180 days**? □Yes □ No

Has the member had a history of a **renal transplant** within the last **365 days**? □Yes □ No

Has the member had a diagnosis of **Panhypopituitarism** within the last **365 days**? □Yes □ No

Has the member had a diagnosis of **HIV** within the last **365 days**? □Yes □ No

Has the member had a diagnosis of **cachexia** within the last **30 days**? □Yes □ No

For Serostim ONLY:

How many previous approvals has the patient had of Serostim?

Please List:_____

For Zorbtive Only:

Has the patient had a diagnosis of **short bowel syndrome** within the last **365 days**? □YES □ NO

How many previous approvals has the patient had of Zorbtive?

Please List:_____

Physician Signature:_____ **Date:** _____