Wellpoint

Growth Hormones Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
			Specify:
7. Diagnosis:			

8. Approval criteria: (Check all boxes that apply. **Note:** Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes	□ No	Is medication is being provided and billed at the physician's office?
□ Yes	□ No	Does the patient have a diagnosis of Growth Hormone Deficiency in the last three years?
□ Yes	□ No	Does the patient have a diagnosis of Idiopathic Short Stature in the last three years?
□ Yes	□ No	Does the patient have a diagnosis of panhypopituitarism in the last three years?
□ Yes	□ No	Does the patient have a diagnosis of SHOX deficiency, Turner syndrome, Noonan syndrome, or Prader-Willi syndrome in the last three years?
□ Yes	□ No	Does the patient have a diagnosis of Chronic Kidney Disease in the last three years?
□ Yes	□ No	Does the patient have a history of rental transplant in the last three years?
□ Yes	□ No	Does the patient have a diagnosis of active malignancy in the last 180 days?
□ Yes	□ No	Does the patient have a history of chemotherapy/radiation in the last 180 days?
□ Yes	□ No	Does the patient have a diagnosis of active proliferative or severe nonproliferative diabetic retinopathy in the last 365 days?
□ Yes	□ No	Does the patient have a diagnosis of HIV in the last three years?
□ Yes	□ No	Does the patient have a diagnosis of cachexia in the last 365 days?

□ Yes □ No Does the patient have a diagnosis of short bowel syndrome in the last three years?
□ Yes □ No Is the client greater than or equal to (≥) 1 year of age and weigh greater than or equal to (≥) 11.5 kg?
□ Yes □ No Does the client have a diagnosis of obstructive sleep apnea in the last 365 days?
□ Yes □ No Does the client have a history of CPAP or BiPAP in the last 730 days?
□ Yes □ No Does the client have a diagnosis of papilledema in the last 180 days?

Additional for nonpreferred growth hormone products

□ Yes □ No Patient has failed a 30-day treatment trial with at least one preferred agent within the past 180 days.
If yes, please indicate which agent(s): _____
□ Yes □ No Patient has a documented allergy or contraindication to preferred agents (at least one) in this class.
If yes, please indicate which agent(s): _____
□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the *Texas Medicaid Preferred Drug List,* please refer to the Texas Medicaid Vendor Drug Program website at **https://www.txvendordrug.com/formulary/formulary-search**

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.