Prior Authorization Form

Molina Healthcare of Texas

Growth Hormone - Excluding Serostim/Zorbtive (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Growth Hormone -Excluding Serostim/Zorbtive (Medicaid).

Drug Name (select from list of drugs shown)	
☐ Genotropin Cartridge	☐ Nutropin AQ Vial
☐ Genotropin Miniquick	☐ Nutropin AQ Pen Cart
☐ Humatrope Cartridge	☐ Nutropin AQ Nuspin Pen Cart
☐ Humatrope Vial	☐ Omnitrope Cartridge
☐ Norditropin Cartridge	☐ Omnitrope Vial
☐ Norditropin Flexpro	☐ Saizen Vial
☐ Norditropin Nordiflex	☐ Saizen Click Easy Cartridge
☐ Nutropin Vial	☐ Tev-Tropin Vial

Patient Information	
Patient Name:	
Patient ID:	
Patient Group No.:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:

Please circle the appropriate answer for each question.

1. Is the patient 0 to 16 (> 0 and ≤ 16) years of age? ☐ Y ☐ N
   If the answer to this question is yes, go to question 2.
   If the answer to this question is no, go to question 6.

2. Does the patient have a diagnosis of short stature, renal failure, or Turner's Syndrome in the last 365 days? ☐ Y ☐ N
   If the answer to this question is yes, go to question 3.
   If the answer to this question is no, denied.

3. Does the patient have a diagnosis of Down's or Fanconi Syndrome in the last 365 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 4.

4. Does the patient have a diagnosis of active malignancy in the last 180 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 5.

5. Does the patient have a history of chemotherapy/radiation (CPTs) in the last 180 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 9.

6. Does the patient have a diagnosis of Panhypopituitarism in the last 365 days? ☐ Y ☐ N
   If the answer to this question is yes, go to question 7.
   If the answer to this question is no, denied.

7. Does the patient have a diagnosis of active malignancy in the last 180 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 8.

8. Does the patient have a history of chemotherapy/radiation (CPTs) in the last 180 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

9. Does the patient have a history of a renal transplant (CPT) in the last 365 days? ☐ Y ☐ N
   If the answer to this question is yes, denied.
   If the answer to this question is no, go to question 10.

10. Is this request for a non-preferred drug? ☐ Y ☐ N
    The Texas Medicaid Preferred Drug List can be found at txvendordrug.com
    If the answer to this question is yes, go to question 11.
    If the answer to this question is no, approved for 365 days.

11. Has the patient had a treatment failure, contraindication, or allergic reaction to a preferred drug within any subclass? ☐ Y ☐ N
    If yes, <u>please list</u> which drug, dates tried, and describe treatment failure, contraindication, or allergy.

    _____
    If the answer to this question is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date