

## **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.

Recipient's Medicaid ID #								I	Date of Birth (MM/DD/YYYY)																		
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Recip	ient's F	ull Nar	ne		ļ				L			j		1	_				1	_							
Presc	riber's	Full Na	ıme																								
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Drug:							Qua	ntity						Dosa	ige F	requ	uenc	y:									
Height	<del>!:</del>			in o	r				cm	,	Weig	ht:				lhs	s or				ka	BN	<b>1</b> 1:			kg/r	n2
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Date la	ast seen	by the	pres	cribin	ıg en	idoc	rinolo	gist:																			
Diag	nosis:	(Please	che	ck a	ll th:	at aı	oply a	nd s	sub	mit	pro	ares	ss n	otes	.)												
9																	4.1	<b>.</b> .									
Ш	Doc	ument	ed gi	rowti	h ho	rmo	ne (G	iH) c	lefi	cier	тсу (	trea	ited	by a	boa	ard (	certi	fied	end	ocri	nolo	gist	s)				
		Lowered growth hormone levels secondary to the normal aging process, obesity or depression?																									
		Grow	th ho	rmor	ne de	eficie	ency o	due t	ор	ituit	ary c	lisea	ase,	hypo	othal	amio	c dis	ease	e, tra	uma	, sur	gery	, rac	liatio	n the	erapy	<b>/</b> ,
		acqui	sitior	n as a	an a	dult	or dia	gnos	sis c	durii	ng cl	nildh	ood	?													
	П	Acqu	ired I	mmu	ınod	efici	ency:	Sync	iron	ne (	AID:	S) w	astir	ng or	cac	hexi	a? (	Plea	se s	ubmi	it Hu	man	Gro	wth	for H	IIV	
	_	Wast					-	•		`	•	,		J			`										
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		Date	Thei	rapy	Initi	ated	l:							(.	Auth	oriza	tion	will c	onsis	t of c	ne fo	our-w	eek (	cours	e of	therap	oy.)



## Aetna Better Health® of Florida (MEDICAID)

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Recipient's Full Name																
Date of Birth (MM/DD/YYYY)						•		•	•			•				
Fill in all related test results to must be submitted. (If the req							•		•				•			ıs)
Growth Velocity:													•		(%)	
Growth Plate:	or _	Closed														
Mid-Parental Height:	[(fath	ner's heig	ght + moth	her's he	ight) ÷	2, plus	s 2.5 ir	nches	s (mal	e) oı	r min	us 2	.5 ind	ches	(fem	ale)]
Providers must correct for Th	nyroid Stin	nulating	Hormon	e (TSH)	defic	iency p	orior t	o coi	nduct	ing	a sti	mula	ation	test		
TSH:	mU/L <b>N</b> o	ormal Ra	nge:						Date	): 						
Stimulation Testing: (Copies of Test (ITT). Levodopa and Clon							erred s	stimu	lation	test	is th	e Ins	sulin <sup>-</sup>	Tolera	ance	)
Test 1: type	Peak GH	Value:		ng_	/ ml <b>\$</b>	Standa	rd Pe	ak:			ng /	ml I	Date	!		
Test 2: type	Peak GH	Value:		ng	/ ml <b>\$</b>	Standa	rd Pe	ak: _			ng /	ml l	Date	<u> </u>		
Previous IGF-1 (if applicable)		ng / ml	Norma	ıl range	(for a	ige):						!	Date:	<u> </u>		
Recent IGF-1:		ng / ml	Norma	ıl range	(for a	ige):						!	Date			
Prescriber's Signature:		Date:														
REQUIRED FOR REVIEW: All co copies of related labs. The provi	•			-					ıt chaı	t no	tes), a	and t	the m	ost r	ecen	it

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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