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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Human Growth Hormone – Pediatric Treatment

Request Date: ___ / ___ / _____

Form must be complete, correct, and legible or the PA process can be delayed.

I. BENEFICIARY INFORMATION

First Name | Last Name

Medicaid ID# | Date of Birth (MM/DD/YYYY) | Sex ☐ Male ☐ Female

II. PRESCRIBER'S INFORMATION

Prescriber's First Name | Prescriber's Last Name

National Provider ID # (NPI) | Prescriber's Specialty (Note: Must be a Nephrologist or Pediatric Endocrinologist)

Prescriber's Phone Number | Prescriber's Fax Number

Prescriber's Office Staff Member Completing This Form

Pharmacy | Phone:

III. DRUG INFORMATION

Drug Name: _____ Strength: _____ Duration: _____

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ ICD Code: _____

Birth Weight: _____ Gestational Age at Birth: _____

Last Recorded Height: _____ Date of Measurement: _____

Last Recorded Weight: _____ Date of Measurement: _____

Biological Mother's Height: _____ Biological Father's Height: _____

Therapy: ☐ Initiation ☐ Continuation

Bone Age Studies Results: _____

Epiphyses: ☐ Open ☐ Closed

Has patient been evaluated by: ☐ Endocrinologist ☐ Pediatric Nephrologist

Current Growth Velocity: _____

**** PLEASE ATTACH COPIES OF GROWTH CHARTS TO THIS REQUEST. ****

PRESCRIBER'S SIGNATURE: _____ DATE _____

Fax completed forms to Magellan Rx Management.
All fax requests will be processed in one business day.
To check the status of your request, please call or visit our website.
Revised: September 2015

Fax: 888-603-7696
Phone: 866-247-1181
Website: http://southcarolina.fhsc.com/

Magellan Rx MANAGEMENT℠