SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Human Growth Hormone – Adult Treatment

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

Request Date: ___ / ___ / _____

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** ____________

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:** ____________

Initiation of Therapy: ☐ Yes ☐ No **Continuation of Therapy:** ☐ Yes ☐ No

Provocation Stimulation Test and Findings ____________

1. **Is patient receiving full supplementation of deficient pituitary hormones?** ☐ Yes ☐ No
   1a. **If YES, please list:** ____________
2. **Does the patient have reduced bone mineral density (BMD) using the WHO criteria?** ☐ Yes ☐ No
   2a. **If YES, please provide T-Score:** ____________
3. **Does the patient have a high-risk lipid profile?** ☐ Yes ☐ No
   3a. **If YES, please provide total cholesterol or LDL level:** ____________
4. **Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone?** ☐ Yes ☐ No
   4a. **If YES, please list:** ____________
5. **For renewal, is the patient showing improvement?** ☐ Yes ☐ No
   5a. **Increase in BMD per DEXA scan?** ☐ Yes ☐ No
   5b. **Reduction in lipid panel?** ☐ Yes ☐ No
   Document percent reduction: ____________

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.

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

Magellan Rx MANAGEMENT℠

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