



FLORIDA MEDICAID PRIOR AUTHORIZATION

Human Growth Hormone

Preferred: Genotropin, Ngenla, Norditropin

Non-Preferred: Humatrope, Nutropin, Omnitrope, Saizen, Skytrofa, Sogroya, Zomacton

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Grid for Medicaid ID #

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Drug: _____ Quantity: _____ Dosage Frequency: _____

Height: _____ in or _____ cm Weight: _____ lbs or _____ kg BMI: _____ kg/m²

Date last seen by the prescribing endocrinologist: _____

Diagnosis: (Please check all that apply and submit progress notes.)

- Documented growth hormone (GH) deficiency (treated by a board certified endocrinologists)
Lowered growth hormone levels secondary to the normal aging process, obesity or depression?
Growth hormone deficiency due to pituitary disease, hypothalamic disease, trauma, surgery, radiation therapy, acquisition as an adult or diagnosis during childhood?
Acquired Immunodeficiency Syndrome (AIDS) wasting or cachexia? (Please submit Human Growth for HIV Wasting in Adults (Serostim) Form)
Other: _____ Diagnosis Code: _____
Treatment of short bowel syndrome in patient receiving specialized nutrition support (Zorbitive®)
Date Therapy Initiated: _____ (Authorization will consist of one four-week course of therapy.)



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Date of Birth (MM/DD/YYYY)

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Fill in all related test results below. Medical records and all related official lab reports (dated within the past 6 months) must be submitted. (If the request is for continuation of therapy in a child, the growth information below must be provided.)

Growth Velocity: (SD) and (cm/year) Bone Age: (year) Height: (%)

Growth Plate: Open or Closed

Mid-Parental Height: [(father's height + mother's height) ÷ 2, plus 2.5 inches (male) or minus 2.5 inches (female)]

Providers must correct for Thyroid Stimulating Hormone (TSH) deficiency prior to conducting a stimulation test:

TSH: mU/L Normal Range: Date:

Stimulation Testing: (Copies of official test results must be submitted) The preferred stimulation test is the Insulin Tolerance Test (ITT). Levodopa and Clonidine are not adequate agents for adult testing.

Test 1: type Peak GH Value: ng/mL Standard Peak: ng/mL Date:

Test 2: type Peak GH Value: ng/mL Standard Peak: ng/mL Date:

Previous IGF-1 (if applicable) ng/mL Normal range (for age): Date:

Recent IGF-1: ng/mL Normal range (for age): Date:

Prescriber's Signature: Date:

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-800-310-6826

11.17.2025

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