REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM
GROWTH HORMONE-ADULT

Genotropin®, Humatrope®, Norditropin®, Nutropin AQ®, Omnitrope® Saizen®, Serostim®, Zomacton®, Zorbtive®

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	Diagnosis Code:	

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Norditropin® (somatropin)
Non-Formulary : ☐ Genotropin® (somatropin), ☐ Humatrope® (somatropin), ☐ Nutropin AQ® (somatropin), ☐ Omnitrope® (somatropin), ☐ Saizen® (somatropin), ☐ Serostim® (somatropin), ☐ Zomacton® (somatropin), ☐ Zorbtive® (somatropin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
GROWTH HORMONE DEFICIENCY IN ADULTS			
1. Does the member have the diagnosis of growth hormone deficiency in adults?	☐	☐	
2. Is the ordering provider an endocrinologist?	☐	☐	
3. Does the member have a pituitary hormone deficiency (other than growth hormone) requiring hormone replacement therapy?	☐	☐	**Please provide documentation**
4. Does the member have a pituitary disease or a condition affecting the pituitary (e.g. pituitary tumor, surgical damage, hypothalamic disease, irradiation, trauma, panhypopituitarism, or infiltrative disease)?	☐	☐	**Please provide documentation**
5. Has the member had a growth hormone provocative stimulation test with a measured peak level of <5 ng/mL?	☐	☐	**Please provide documentation**

6. Does the member have 3 pituitary hormone deficiencies (other than growth hormone) that require replacement therapy AND have an insulin-like growth factor (IGF-1) <80 ng/mL?	☐	☒	**Please provide documentation**
SHORT BOWEL SYNDROME			
1. Does the member have the diagnosis of Short Bowel Syndrome?	☐	☐	
2. Is the provider a gastroenterologist?	☐	☐	
3. Is the member able to ingest solid food?	☐	☐	
4. Is the member receiving parenteral nutrition at least 5 days/week to provide at least 3,000 calories per week?	☐	☐	
5. Has the member met with a nutritionist and documentation indicates that dietary needs and goals have been discussed?	☐	☐	**Please provide documentation**
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)			
1. Does the member have the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) Wasting Syndrome in adults?	☐	☐	
2. Is the requesting provider an infectious disease specialist?	☐	☐	
3. Is the member currently take antiretroviral medications?	☐	☐	**Please provide documentation**
4. Does the member have a documented weight loss of at least 10% from baseline weight OR a body mass index (BMI) of <20?	☐	☐	**Please provide documentation**
5. Has the member had an adequate nutritional evaluation and has failed to respond to a high calorie intake diet?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show continued medical necessity and clinical efficacy?	☐	☐	**Please provide documentation**
3. For a diagnosis of AIDS, has the member demonstrated weight gain within the initial 12 weeks of therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
PRESCRIBER CERTIFICATION			
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.			
Physician's Signature:			**Date:**

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Policy: PHARM-MM-027
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/10/2026
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