Alabama Medicaid Pharmacy
Adult Growth Failure PA Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
KEPRO

P.O. Box 3570
Auburn, AL 36831-3210

PATIENT INFORMATION

Patient name________________________________Patient Medicaid # ________________

Patient DOB________________________Patient phone # with area code ________________

PRESCRIBER INFORMATION

Prescriber name____________________NPI #________________License # ________________

Address________________________________Phone # with area code ________________

City/State/Zip________________________________Fax # with area code ________________

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

____
Prescribing Practitioner Signature Date

PHARMACY INFORMATION

Dispensing pharmacy________________________________NPI #________________

NDC #________________________J Code____________Qty. requested per month ____________
if applicable

Phone # with area code________________________ Fax # with area code ________________

DRUG/CLINICAL INFORMATION

❒ Initial request ❒ Renewal Drug requested________________Proposed duration of therapy____________

Strength/Quantity________________Daily dose________________Height__________Weight____________

Patient must have one of the following primary indications listed below, confirmed by a board-certified endocrinologist for growth hormone deficiency or by a board-certified gastroenterologist for short bowel syndrome:

❒ Adult with childhood onset of growth hormone deficiency ❒ Adult onset of growth hormone deficiency with other deficiencies

❒ Adult onset of growth hormone deficiency without other pituitary hormone deficiencies ❒ Short Bowel Syndrome

Diagnostic testing required:

1. IGF-1 Level__________ng/ml Date ________________
2. Is there a contraindication to ITT? ❒ Yes ❒ No
   If yes, indicate reason ____
3. Is the patient's thyroid function normal? ❒ Yes ❒ No
4. Provocative Testing: Check appropriate selection
   ❒ Adult with childhood onset GHD or with additional pituitary hormone deficits (one {1} stimulation test required)
   ❒ Adult with suspected GHD with no other pituitary hormone deficits (two {2} stimulation tests required)
   Test 1: Type ________________ Results__________ng/ml Date____________
   Test 2: Type ________________ Results__________ng/ml Date ____________
5. Has the patient been screened for intracranial malignancy or tumor? ❒ Yes ❒ No (If no, request will be denied)
6. If a history of malignancy exists, have they been free of recurrence for at least the past six (6) months? ❒ Yes ❒ No (If no, request will be denied)
7. Does the patient have any of the following contraindications? Check all that apply. **If any apply, request. will be denied.**
   ❒ Pregnancy ❒ Proliferative or preproliferative diabetic retinopathy ❒ Pseudotumor cerebri or benign intracranial HTS
8. For patients with short bowel syndrome, is the patient receiving specialized nutritional support such as dietary adjustments, enteral feedings, parenteral nutrition, and/or fluid and micronutrient supplement? ❒ Yes ❒ No (If no, request will be denied)

FOR KEPRO USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments ____

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________________________ ________________________
Reviewer's Signature Response Date/Hour