Alabama Medicaid Pharmacy
Child Growth Hormone Deficiency PA Request Form

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

Fax or Mail to
HEALTH INFORMATION DESIGNS

P.O. Box 3210
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 _____ (if applicable) Qty. requested per month _____

Phone # with area code _____ Fax # with area code _____

DRUG/CLINICAL INFORMATION

❒ Initial Request ❒ Renewal* Drug Requested _____ Duration of Therapy _____

Strength/Quantity _____ Daily Dose _____ Height _____

Does the patient have a diagnosis of Growth Hormone Deficiency and has therapy been approved by a board certified endocrinologist? ❒ Yes ❒ No

Has Growth Hormone Deficiency been confirmed with Provocative Testing? ❒ Yes ❒ No

Test 1: Type_____ Result_____ Date_____

Test 2: Type_____ Result_____ Date_____

Indicate at least **one** of the measurements below:

Patient's height in standard deviations below the mean _____, ***or***

Patient's midparental height percentile in standard deviations below the mean_____, ***or***

Patient's height percentile_____

Is the patient's growth velocity <25th percentile for bone age? (Must be calculated over a minimum of 6 months)

❒ Yes ❒ No Indicate dates measured: _____

Does the patient have other documented pituitary hormone deficiencies? ❒ Yes ❒ No

If yes, are they being treated appropriately? ❒ Yes ❒ No

Does the patient have normal thyroid function? ❒ Yes ❒ No

Has the patient been screened for intracranial malignancy or tumor? ❒ Yes ❒ No

If a history of malignancy exists, has the patient been free of recurrence for at least the past 6 months? ❒ Yes ❒ No

Does the patient have any of the following contraindications?

❒ Yes

❒ Proliferative or pre-proliferative diabetic retinopathy ❒ Pseudotumor cerebri or benign intracranial hypertension

❒ Pregnancy ❒ Multiple pituitary hormone deficiencies ❒ Closed epiphyses

❒ No

*For renewal requests, indicate the patient's growth velocity in cm/year since the patient was initiated on the requested medication. _____

FOR HID USE ONLY

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

Comments _____

_____

_____

_____ _____

Reviewer's Signature Response Date/Hour