

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 36832-3210

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 _____ 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 _____