## Alabama Medicaid Pharmacy Child Growth Hormone /

## Turner Syndrome, Prader-Willi Syndrome, Noonan Syndrome PA Request Form

FAX: (800) 748-0116 Phone: (800) 748-0130		Fax or Mail to Health Information Designs			A	P.O. Box 3210 uburn, AL 36831-3210
		— PATII	ENT INFORM	IATION		
Patient name				t Medicaid #		
Patient DOB			Patient phone # with area code			
		PRESCE	RIBER INFOI	RMATION		
Prescriber name			NPI #		License #	
Address				Phone #	with area code	
City/State/Zip				Fax # w	vith area code	
I certify that this treatment is supervising the patient's treatment		•	-		•	icaid Agency. I will be
				Prescribir	ng Practitioner Signature	Date
		— PHARM	IACY INFOR	MATION		
Dispensing pharmacy					NPI #	
NDC #			J Code	1: 11	Qty. requested per 1	month
Phone # with area code			11 ap	Fax # with ar		
				ORMATION •		
	Turner Sy	ndrome, Prado	er-Willi Synd	lrome, Noona	an Syndrome	
☐ Initial Request ☐	Renewal*	Orug Requested		Duration	of Therapy	
Strength/Quantity		Daily Dose		Heigl	ht	
Does the patient have a dia by a board certified pediati				rome, or Noona	an Syndrome and has t	herapy been approved
For Turner Syndrome, has	diagnosis been	confirmed by kar	otyping?   Y	es 🗖 No		
Does the patient have norm	nal thyroid funct	ion? ☐ Yes ☐	<b>J</b> No			
Has the patient been screen If a history of ma months?  Yes	lignancy exists,				east the past 6	
☐ Severely o	ve or pre-prolife	rative diabetic re espiratory impair	tinopathy			ntracranial hypertension
*For renewal requests, indica	te the patient's gro	wth velocity in cn	n/year since the j	patient was initia	ted on the requested med	lication.
☐ Approve request Comments		y request		odify request		d eligibility verified
Reviewer's Signature					Response Date/Hour	

Form 410-B Rev. 9-15-12