

Alabama Medicaid Pharmacy
Child Growth Failure / Mecasermin 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 _____ 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 primary insulin-like growth factor-1 deficiency (primary IGFD) and has therapy been approved by a board certified pediatric endocrinologist? Yes No

Indicate the patient's height score in standard deviations. _____

What is the patient's basal IGF-1 score in standard deviations? Yes No

Does the patient have normal or elevated growth hormone levels? Yes No

Does the patient have a diagnosis of growth hormone gene deletion with neutralizing antibodies to growth? Yes No

Does the patient have other causes of growth failure (e.g. growth hormone deficiency, malnutrition, hypothyroidism, chronic anti-inflammatory steroid use) or active or suspected neoplasia? Yes No

Does the patient have any of the following contraindications?

- Yes
 Pseudotumor cerebri or benign intracranial hypertension Pregnancy 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 _____