

**Alabama Medicaid Pharmacy  
Adult Growth Failure 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 \_\_\_\_\_  
Phone # with area code \_\_\_\_\_ Fax # with area code \_\_\_\_\_  
if applicable

**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 HIM USE ONLY**

- Approve request                       Deny request                       Modify request                       Medicaid eligibility verified

Comments \_\_\_\_\_

Reviewer's Signature \_\_\_\_\_  
Form 411  
Revised 1/30/08

Response Date/Hour \_\_\_\_\_

Alabama Medicaid Agency  
www.medicaid.alabama.gov