

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
Kepro

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

Turner Syndrome, Prader-Willi Syndrome, Noonan Syndrome

Initial Request Renewal* Drug Requested _____ Duration of Therapy _____
Strength/Quantity _____ Daily Dose _____ Height _____

Does the patient have a diagnosis of Turner Syndrome, Prader-Willi Syndrome, or Noonan Syndrome and has therapy been approved by a board certified pediatric endocrinologist? Yes No

For Turner Syndrome, has diagnosis been confirmed by karyotyping? 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
 - Severely obese or severe respiratory impairment (for Prader-Willi Syndrome)
 - 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 KEPRO USE ONLY

Approve request Deny request Modify request Medicaid eligibility verified

Comments _____

Reviewer's Signature _____

Response Date/Hour _____