Alabama Medicaid Pharmacy
Child Growth Failure / Mecasermin PA Request Form

FAX: (800) 748-0116	**Fax or Mail to**	**P.O. Box 3210**
Phone: (800) 748-0130	**Kepro**	**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_____ (if applicable) Qty. requested per month _____

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 KEPRO USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments _____

_____

_____

_____ _____
Reviewer's Signature Response Date/Hour