Alabama Medicaid Pharmacy
Child Growth Hormone /Chronic Renal Insufficiency 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 _____

*For renewal requests, progress reports including information regarding efficacy, adverse effects, and compliance must be included. The report must include date the patient was last seen by the physician.

Does the patient have a diagnosis of Chronic Renal Insufficiency and therapy has been approved by a board certified pediatric endocrinologist or board certified pediatric nephrologist? ☐ Yes ☐ No

What is the patient's Glomerular Filtration Rate (GFR)? _____

Indicate at least **one** of the 2 measurements below:
Patient's height in standard deviations below the mean_____, ***or***
Patient's midparental height percentile in standard deviations below the mean_____

Is the patient's growth velocity <25th percentile for bone age? (Must be calculated over a minimum of 6 months)
☐ Yes ☐ No Indicate dates measured: _____

Is the patient pre-transplant? ☐ 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
☐ Pregnancy ☐ Closed epiphyses
☐ No

FOR KEPRO USE ONLY

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

Comments _____

_____

_____

_____ _____
Reviewer's Signature Response Date/Hour