Alabama Medicaid Pharmacy
Adult Growth Failure 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 _____
if applicable

Phone # with area code _____ Fax # with area code _____

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 KEPRO USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

_____ _____
Reviewer's Signature Response Date/Hour