

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____																					
SECTION A - PATIENT INFORMATION																					
First Name:		Last Name:																			
Address:		Member ID:																			
City:	State:	Zip:																			
Phone:	DOB:	Allergies:																			
Primary Insurance:	Policy #:	Group #:																			
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____																					
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No																					
SECTION B - PHYSICIAN INFORMATION																					
First Name:		Last Name: M.D./D.O.																			
Address:		City:	State: Zip:																		
Phone:	Fax:	NPI #:	Specialty:																		
Office Contact Name / Fax Attention to: _____																					
Medication to be Administered: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home																					
Deliver Rx to: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other Address: _____																					
<input type="checkbox"/> Patient's Home _____																					
SECTION C - MEDICAL INFORMATION																					
Medication:		Strength:																			
Directions for use: _____																					
Diagnosis (Please be specific & provide as much information as possible):			ICD-9 CODE:																		
<ul style="list-style-type: none"> What is the patient's diagnosis? (Please provide ICD-9 code above) Is patient currently receiving growth hormone therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for how long? (Please provide start date) <table border="1" style="width: 100%; border-collapse: collapse; margin: 10px 0;"> <tr> <td style="width: 50%;">Growth Velocity</td> <td style="width: 50%;"></td> </tr> <tr> <td>Bone Age</td> <td></td> </tr> <tr> <td>IGF-1 Value</td> <td></td> </tr> </table> <ul style="list-style-type: none"> Is the patient's Epiphyses: OPEN or CLOSED Is the patient's height below the 3rd percentile on growth for age and gender? BELOW _____ PERCENTILE <table border="1" style="width: 100%; border-collapse: collapse; margin: 10px 0;"> <tr> <td style="width: 25%;"># Provocative Tests</td> <td style="width: 25%;"></td> <td style="width: 25%;">Test Result (GH ng/ml)</td> <td style="width: 25%;"></td> </tr> <tr> <td>Baseline Height/Date</td> <td></td> <td>Current Height</td> <td></td> </tr> <tr> <td>Baseline Weight/Date</td> <td></td> <td>Current Weight</td> <td></td> </tr> </table> <p style="text-align: center; font-weight: bold; margin: 10px 0;">*** PLEASE FAX ALL APPROPRIATE SUPPORTING DOCUMENTATION WITH THIS REQUEST***</p> <ol style="list-style-type: none"> 1. Wrist film evaluation 2. Growth Chart/ Office Notes 3. IGF-1, IGF-1 PROVOCATIVE TEST, ETC. 				Growth Velocity		Bone Age		IGF-1 Value		# Provocative Tests		Test Result (GH ng/ml)		Baseline Height/Date		Current Height		Baseline Weight/Date		Current Weight	
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