



Growth Hormones

PATIENT NAME _____

D.O.B. ___/___/___ MEMBER ID# _____ DURATION _____

DRUG REQUESTED _____

DOSAGE and Sig. _____ FAX ATTENTION: _____

PHYSICIAN (PLEASE PRINT) _____ PH# () _____ FAX# () _____

PHYSICIAN ADDRESS _____

***Please Note:** ALL are required fields above

<< Additional Drug Specific forms are available at UnisonHealthPlan.com >>

Patient diagnosis _____

FOR CHILDREN: PLEASE ATTACH APPROPRIATE SUPPORTING DOCUMENTATION

1. Has the patient failed 2 (two) provocative growth hormone tests?

Circle: YES or NO

(applicable for children)

2. *Please submit a copy of the growth grid (required for consideration of request).*

FOR ADULTS: PLEASE ATTACH APPROPRIATE SUPPORTING DOCUMENTATION

1. If patient diagnosis is somatotropin deficiency syndrome, please confirm reason for this diagnosis _____

2. Does the patient have the biochemical diagnosis of deficiency syndrome by confirming a negative response to a standard growth hormone stimulation test?

Circle: YES or NO

3. If patient diagnosed as child and is now adult, does the patient now have a current diagnosis of somatotropin deficiency syndrome? Circle: YES or NO

4. Additional information : _____

PLEASE ATTACH APPROPRIATE SUPPORTING DOCUMENTATION

The purpose of this worksheet is to provide complete information regarding the physician's request for a non-formulary or prior authorization medication. It will be reviewed and notification of approval or denial will be given within 24 hours. Thank you.

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