# Alabama Medicaid Pharmacy
# Child Growth Hormone Deficiency PA Request Form

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| **FAX: (800) 748-0116** | **Fax or Mail to** | **P.O. Box 3570** |
| **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 Growth Hormone Deficiency and has therapy been approved by a board-certified endocrinologist? ☐ Yes ☐ No

Has Growth Hormone Deficiency been confirmed with Provocative Testing? ☐ Yes ☐ No

Test 1: Type_____ Result_____ Date_____

Test 2: Type_____ Result_____ Date_____

Indicate at least **one** of the measurements below:

Patient's height in standard deviations below the mean_____, ***or***

Patient's midparental height percentile in standard deviations below the mean_____, ***or***

Patient's height percentile_____

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:_____

Does the patient have other documented pituitary hormone deficiencies? ☐ Yes ☐ No

If yes, are they being treated appropriately? ☐ 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 ☐ Multiple pituitary hormone deficiencies ☐ 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