Alabama Medicaid Pharmacy
Child Growth Hormone / Turner Syndrome, Prader-Willi Syndrome, Noonan Syndrome PA Request Form

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

Turner Syndrome, Prader-Willi Syndrome, Noonan Syndrome

☐ Initial Request ☐ Renewal* Drug Requested_____ Duration of Therapy_____

Strength/Quantity_____ Daily Dose_____ Height_____

Does the patient have a diagnosis of Turner Syndrome, Prader-Willi Syndrome, or Noonan Syndrome and has therapy been approved by a board-certified pediatric endocrinologist? ☐ Yes ☐ No

For Turner Syndrome, has diagnosis been confirmed by karyotyping? ☐ 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
- ☐ Severely obese or severe respiratory impairment (for Prader-Willi Syndrome)
- ☐ Pregnancy ☐ 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_____

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Reviewer's Signature Response Date/Hour