Alabama Medicaid Pharmacy
Child Growth Hormone /Chronic Renal Insufficiency 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_____Qty. requested per month_____
if applicable

Phone # with area code_____ Fax # with area code_____

DRUG/CLINICAL INFORMATION

☐ Initial Request ☐ Renewal* Drug Requested_____Duration of Therapy_____

Strength/Quantity_____Daily Dose_____Height_____

*For renewal requests, progress reports including information regarding efficacy, adverse effects, and compliance must be included. The report must include date the patient was last seen by the physician.

Does the patient have a diagnosis of Chronic Renal Insufficiency and therapy has been approved by a board-certified pediatric endocrinologist or board-certified pediatric nephrologist? ☐ Yes ☐ No

What is the patient's Glomerular Filtration Rate (GFR)?_____

Indicate at least one of the 2 measurements below:

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

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

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:_____

Is the patient pre-transplant? ☐ 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
- ☐ Closed epiphyses

☐ No

FOR KEPRO USE ONLY

☐ Approve request ☐ Deny request ☐ Modify request ☐ Medicaid eligibility verified

Comments_____

_____

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_____ _____

Reviewer's Signature Response Date/Hour