

Growth Hormone (GH) Prior Authorization Request

IGF-I level & reference range IGFBP3 level & reference range MRI results (Initial panhypopituitarism only)	Member Name:	SoonerCare ID #	#:	Date of Birth:
Prescriber NPI #: Prescriber Name: Specialty: Prescriber Phone: Prescriber Fax:	Pharmacy NPI #:	Pharmacy Phone	e:	Pharmacy Fax:
Prescriber Phone: Prescriber Fax: MEDICATION REOUESTED: Drug Name Strength Daily dose Refills: DC # Fill Date Fill Quantity Day Supply INICAL INFORMATION: Date of Most Recent Clinic Visit	Pharmacy Name:	Pharmacist Nar	ne:	
MEDICATION REQUESTED: Drug Name Strength Daily dose Refills: Drug Name Fill Date Fill Quantity Day Supply DC # Fill Date of Most Recent Clinic Visit	Prescriber NPI #:	Prescriber Nam	le:	Specialty:
Drug Name Strength Daily dose Refills:	Prescriber Phone:	Prescriber Fax:		
DC #	MEDICATION REQUESTED:			
INICAL INFORMATION: Date of Most Recent Clinic Visit Initial Request (Please complete the information requested below.) Renewal: Growth Velocity (cm/yr): ; Compliant with GH therapy: Yes_No_ Physical Stature Percentile ; Height cm; Weight kg; TannerStage Primary Diagnosis Short Stature Associated with Chronic Renal Failure, Creatinine Clearance < 50mL/min; CrCl mL/min (CRF only) Dialysis: YesNo Transplant: YesNo Turner Syndrome diagnosed by karyotyping: Karyotype Results Date of Test Date of Test Prader-Willi Syndrome diagnosed by karyotyping: Karyotype Results Date of Test Small for Gestational Age: Birth Weight kg; Gestational Age wks Idiopathic Short Stature (8 years and older) Dacumented GH deficiency (pituitary dwarfism, panhypopituitarism) Hypoglycemic: YesNo Glucose:mg/dL Other (specify) cm; Height cm; Midparental Height cm Mother's Height cm; Midparental Height cm Mother's Height cm; Father's Height cm; Midparental Height cm Mother's Lase of Scan Bone Age Yr Mo; Chronological Age Yr Mo; Date of Scan All causes for short stature, other than GH deficiency, ruled out? Yes	Drug Name	Strength	Daily dose _	Refills:
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I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge.

Prescriber/Pharmacist Signature: _____ Date: _____

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