Oklahoma HealthCare Authority

Growth Hormone (GH) Prior Authorization Request

Member Name: _____ SoonerCare ID #: _____ Date of Birth: _____

Pharmacy NPI #: _____ Pharmacy Phone: _____ Pharmacy Fax: _____

Pharmacy Name: _____ Pharmacist Name: _____

Prescriber NPI #: _____ Prescriber Name: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

MEDICATION REQUESTED:

Drug Name _____ Strength _____ Daily dose _____ Refills: _____

NDC # _____ Fill Date _____ Fill Quantity _____ Day Supply _____

CLINICAL 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; Tanner Stage _____

Primary Diagnosis

☐ **Short Stature Associated with Chronic Renal Failure, Creatinine Clearance < 50mL/min;**
CrCl _____ mL/min (CRF only) Dialysis: Yes___ No___ Transplant: Yes___ No___

☐ **Turner Syndrome** diagnosed by karyotyping: Karyotype Results _____ 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)

☐ **Documented GH deficiency (pituitary dwarfism, panhypopituitarism)** Hypoglycemic: Yes___ No___

☐ Glucose: _____mg/dL **Other** (specify) _____ (Additional information may be required)

Diagnostic Testing (Please complete for Initial Requests and when Applicable)

Physical Stature Percentile _____; Height _____ cm; Weight _____ kg; Tanner Stage____

Mother's Height _____ cm; Father's Height _____ cm; Midparental Height_____ cm

Pretreatment Growth Velocity _____ cm/yr; Epiphyses Open: Yes___ No___

Bone Age _____ Yr _____ Mo; Chronological Age _____ Yr _____ Mo; Date of Scan_____

All causes for short stature, other than GH deficiency, ruled out? Yes___ No___

Provocative testing: (Initial GHD Only)

Agent: (a) _____b) _____ Peak (a) _____ (b) _____ Date_____

IGF-1 level & reference range _____ IGFBP3 level & reference range_____

MRI results (Initial panhypopituitarism only)_____

What, if any, hormone replacement therapy, is member receiving:_____

Additional Information:_____

_____

_____

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: _____

Please Provide the Information Requested and Return to: UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS PRODUCT
BASED PRIOR AUTHORIZATION UNIT

Fax *OKC Metro:* 405-271-4014 *Toll Free:* 1-800-224-4014
Phone *OKC Metro:* 405-522-6205 Opt 4 *Toll Free* 1-800-522-0114 Opt 4