Oklahoma Health Care 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: ____

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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: ____________________

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

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