



Physician Request Form for Patient Self-Administered Growth Hormone

Fax non-urgent requests to PerformRx Pharmacy Services at 877-693-8280 or urgent requests to 877-693-8476. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call 800-578-0898. Form must be completed for processing

Patient's Name: _____ Plan ID#: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg Birth date: _____

Physician's Name: _____ NPI #: _____
Address: _____ Apt # or Suite #: _____
City: _____ State: _____ Zip Code: _____
Contact Person: _____ Phone #: _____ Fax #: _____
Physician Signature: _____ Date: _____

To be Administered from: _____ to _____ or on: _____
Drug Name: _____ Dose: _____
Sig (How Administered): _____
Diagnosis: _____ ICD-9 Diagnosis Code: _____

Required Laboratory Values for GH deficiency States – Either complete below and/or submit lab results with request

1. Type of GH Stimulation Test Performed _____ Peak GH Levels _____ Age Reference Range: _____ Date Tested: _____
2. IGF-1 Level: _____ Age Reference Range: _____ Date Tested: _____

It is recommended that as an adolescent approaches adulthood that he/she gets re-evaluated for GH deficiency.

3. Is the patient 17 years of age or older? [] No [] Yes
If yes, has the patient been re-evaluated to see if they still have a medical necessity for GH? [] No [] Yes
If yes, was GH therapy stopped and what were the resulting GH and IGF-1 levels? Period Stopped: _____

GH Stimulation Test Performed _____ Peak GH Levels _____ Age Reference Range: _____ Date Tested: _____
IGF-1 Level: _____ Age Reference Range: _____ Date Tested: _____

4. If the patient is 17 or older and still requires GH, has the dose been adjusted to adult dosing guidelines? [] No [] Yes
If no, did the patient reach their predicted maximum height? If no, please provide medical documentation of expected height .
If yes, please provide documented medical reason to continue therapy at a childhood dosing level.

Additional information to justify medical necessity of GH therapy (i.e. TSH, testosterone, FSH/LH) or attach additional information with form:

Note: Delivered by PerformRx Specialty Pharmacy Provider Only. Delivered Directly to the Patient's Home or Physician's Office (for Patient Instruction)
[] Deliver to Patient's Home [] Deliver to Physician's Office [] Patient Filling at Local Pharmacy

Pharmacy Name: _____ Fax Number: _____ Phone Number: _____

If the information requested above is not included with the Growth Hormone request form, this may result in denial due to insufficient information or delays in authorization.