

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: _____

Drug Name: _____ To be Administered from: _____ to _____
Dose: _____ Sig (How Administered): _____
Diagnosis: _____ ICD-9 Diagnosis Code: _____ LTC member Yes No, Date Admitted _____

Required Laboratory Values for GH deficiency States – Either complete below and/or submit lab results with request (please attach any additional information):

- 1. Type of GH Stimulation Test Performed _____ Peak GH Levels _____ Age Reference Range: _____ Date Tested: _____
- 2. Type of GH Stimulation Test Performed _____ Peak GH Levels _____ Age Reference Range: _____ Date Tested: _____
- 3. IGF-1 Level: _____ Age Reference Range: _____ Date Tested: _____
- 4. Growth Velocity: _____ cm/year OR _____ percentile for age and gender
- 5. In terms of the patient's height, the standard deviation (SD) below the mean for age = _____ or SD below the mid-parental height percentile = _____

It is recommended that as an adolescent approaches adulthood that he/she gets re-evaluated for GH deficiency (please attach any additional information):

- 6. 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: _____
- 7. 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 (attach any necessary documentation):

8. If requesting a medication other than **Genotropin®**, please provide documentation of a medical reason for why the patient is unable to take **Genotropin®** to treat their medical condition (attach any necessary documentation):

Note: Delivered by Keystone Mercy 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.

