

SOUTH CAROLINA MEDICAID PROGRAM

GROWTH HORMONE PRIOR AUTHORIZATION REQUEST – ADULT TREATMENT

<p>PRESCRIBER:</p> <p>NAME: _____ (FIRST) (LAST)</p> <p>Prescriber Specialty: _____</p> <p>PHONE # (____) _____</p> <p>FAX # (____) _____</p> <p>PRESCRIBER'S OFFICE STAFF MEMBER COMPLETING FORM: _____</p>	<p>BENEFICIARY:</p> <p>NAME: _____ (FIRST) (LAST)</p> <p>MEDICAID #: _____</p> <p>DATE OF BIRTH: ___/___/___ SEX: <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>REQUEST DATE: ___/___/___</p>
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PHARMACY: _____ **PHONE:** (____) _____

DRUG NAME	STRENGTH	DURATION

If request is for a non-preferred agent, please include clinical criteria for this particular agent over one of the following: Genotropin®, Norditropin®, Saizen®

Dosage Schedule: _____

Diagnosis: _____ **ICD-9 CODE:** _____

Initiation of Therapy: Yes No **Continuation of Therapy:** Yes No

Provocative Stimulation Test and Findings : _____

Is patient receiving full supplementation of deficient pituitary hormones? Yes No
If yes, please list _____

Does the patient have reduced bone mineral density (BMD) using the WHO criteria? Yes No
If yes, please provide T-Score: _____

Does the patient have a high risk lipid profile? Yes No
If yes, please provide total cholesterol or LDL level: _____

Does the patient have at least 2 pituitary hormone deficiencies other than Growth Hormone? Yes No
If yes, please list: _____

For renewal, is the patient showing improvement? Yes No
* Increase in BMD per DEXA scan: Yes No
* Reduction in lipid panel: Yes No
Document percent reduction: _____

Prescriber's Signature: _____ **Date:** ___/___/___

SUBMIT REQUESTS TO:	FIRST HEALTH SERVICES	FAX: (888) 603-7696
All Fax requests will be processed in one business day To check on the status you may call TELEPHONE: (866) 247-1181		
WEB REQUESTS: PA's may be requested on-line see the following website for details: http://southcarolina.fhsc.com/		