Physician Request Form for Patient Self-Administered Growth Hormone

AmeriHealth Caritas District of Columbia

Fax to Pharmacy Services at **855-811-9332**, or to speak to a representative call **888-602-3741**. *Form must be completed for processing.*

Patient's Name: _____ Patient 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 #: _____

RX: Drug Name: _____ Quantity (for a 1 month supply): _____ Refills _____

Pen Needles _____ G x _____ mm/in Quantity: _____ Refills _____

Dose: _____ Sig (How Administered): _____

Physician Signature: _____ Date: _____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

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 = _____

6. Patients with Prader Willi Syndrome, do they have upper airway obstruction, sleep apnea, or severe resipiratory impairment? □ No □ Yes

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 **Humatrope**® please provide documentation of a medical reason for why the patient is unable to take **Humatrope**® to treat their medical condition (attach any necessary documentation):

Note: Delivered by AmeriHealth Caritas District of Columbia 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: _____