



**Growth Hormone PA Form**

**Fax Completed Form to:  
866-254-0761  
For questions regarding this  
Prior authorization, call  
866-773-0695**

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that patients receiving Growth Hormone meet one of the criteria below:

- **Growth Hormone Deficiency in children and adults with a history of hypothalamic pituitary disease**
- **Short stature associated with chronic renal insufficiency before renal transplantation**
- **Short stature in patients with Turners Syndrome (TS) or Prader-Willi Syndrome (PWS)**
- **Human Immunodeficiency Virus (HIV) associated wasting in adults**

**Part I: TO BE COMPLETED BY PRESCRIBER**

|   |  |                                   |
|---|--|-----------------------------------|
| RECIPIENT NAME:                               |  | RECIPIENT<br>MEDICAID ID NUMBER:  |
| Recipient<br>Date of birth:        /        / |  |                                   |
| PRESCRIBER NAME                               |  | PRESCRIBER<br>MEDICAID ID NUMBER: |
| Address:                                      |  | Phone: (     )                    |
| City:   |  | FAX: (     )                      |
| State:  | Zip:   |                                   |
| <b>REQUESTED DRUG:</b>                        | <b>Requested Dosage:</b> (must be completed) |                                   |
| <b>Qualifications for coverage:</b>           |  |                                   |
| Criteria met:                                 | Diagnosis Date:<br>Drug:                     | Dose:<br>Frequency:               |
| PRESCRIBER SIGNATURE                          |  | DATE:                             |

**Part II: TO BE COMPLETED BY PHARMACY**

|                |                                 |
|----------------|---------------------------------|
| PHARMACY NAME: | ND MEDICAID<br>PROVIDER NUMBER: |
| Phone:         | FAX:                            |
| Drug:          | NDC#:                           |

**Part III: FOR OFFICIAL USE ONLY**

|   |   |
|---|---|
| Date:                                /                                /   | Initials: _____   |
| Approved -<br>Effective dates of PA:    From:                                /                                / | To:                                /                                / |
| Denied: (Reasons)   |   |
|   |   |