

**PRIOR AUTHORIZATION REQUEST FORM**SD DEPARTMENT OF SOCIAL SERVICES
MEDICAL SERVICES DIVISION**ADULT GROWTH HORMONE**

Please fill out form completely

Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-705-5391

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

| | |
|-----------------|----------------------------------|
| RECIPIENT NAME: | RECIPIENT MEDICAID ID NUMBER: |
| RECIPIENT DOB: | |

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

| | |
|--|--------------------------|
| PHYSICIAN NAME: | PHYSICIAN DEA NUMBER: |
| Is prescribing physician board certified endocrinologist or gastroenterologist ? <input type="checkbox"/> YES <input type="checkbox"/> NO | PHONE: FAX: |

Part III: TO BE COMPLETED BY PHYSICIAN:

| | |
|---|---------------------------------------|
| REQUESTED DRUG: | Requested Dosage: (must be completed) |
| <input type="checkbox"/> INITIAL REQUEST <input type="checkbox"/> RENEWAL REQUEST | Diagnosis for this request: |

QUALIFICATIONS FOR COVERAGE:

Does patient have a diagnosis of: Panhypopituitarism **OR** Prader-Willi Syndrome (If either, may skip questions 1, 2, & 3)

1. IGF-1 Level:

2. Provocative testing:

Type _____ Results _____ Date _____

Type _____ Results _____ Date _____

3. Has the patient been screened for intracranial malignancy or tumor? YES NO

4. Does the patient have any of the following contraindications? Check all that apply.
 Proliferative Diabetic retinopathy Benign intracranial hypertension NONE

Physician signature: _____ Date: _____

Part IV: PHARMACY INFORMATION

| | |
|----------------|---------------------------------|
| PHARMACY NAME: | SD MEDICAID PROVIDER NUMBER: |
| PHONE: | FAX: |
| DRUG NAME: | NDC#: |