



PRIOR AUTHORIZATION REQUEST FORM
 SD DEPARTMENT OF SOCIAL SERVICES
 MEDICAL SERVICES DIVISION

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

PEDIATRIC GROWTH HORMONE

Please fill out form completely (Note: if this is a renewal request, please include height chart and documentation regarding efficacy with the request)

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 nephrologist? <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:

(Renewal requests do NOT need to answer the questions below, please submit height chart and documentation of efficacy):

For Growth Hormone Deficiency (please submit either IGF-1 level OR provocative testing results):

IGF-1 Level: _____

Provocative testing: Type _____ Results _____ Date _____

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

For GHD AND Chronic Renal Insufficiency:

Is the patient's height value or growth velocity less than 2 standard deviations below the mean for age and/or Tanner Stage?
 YES NO

For Idiopathic Short Stature and SGA:

Please indicate patients height or include chart documentation:

Please indicate patient's predicted height:

For All Patients:

Does the patient have any of the following contraindications? Check all that apply.

- Benign intracranial hypertension Closed epiphyses NONE

Physician signature:	Date:
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Part IV: PHARMACY INFORMATION

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