Physician Request Form for Patient Self-Administered Growth Hormone

Fax to AmeriHealth Mercy Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. *Form must be completed for processing.*

Patient's Name: ______________________ AmeriHealth Mercy ID#: ______________

Address: ______________________ Apt # or Suite #: ______________

City: ______________ State: __________ Zip Code: ______________

Phone #: __________ Height: ______ Weight: ______ lbs = ______ Kg Birthdate: ______________

Physician's Name: ______________________ NPI #: ______________

Address: ______________________ Apt # or Suite #: ______________

City: ______________ State: __________ Zip Code: ______________

Contact Person: ______________ Phone #: __________ Fax #: ______________

Physician Signature: ______________________ Date: ______________

To be Administered from: __________ to __________ or on: __________

Drug Name: ______________________ Dose: ______________

Sig (How Administered): ______________________

Diagnosis: ______________________ ICD-9 Diagnosis Code: ______________

Required Laboratory Values for GH deficiency States – Either complete below and/or submit lab results with request

1. Type of GH Stimulation Test Performed______________Peak GH Levels ________ Age Reference Range: ______________Date Tested: ________
2. IGF-1 Level: ________Age Reference Range: ____________ ____Date Tested: ______________

It is recommended that as an adolescent approaches adulthood that he/she gets re-evaluated for GH deficiency.

3. 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: ______________

GH Stimulation Test Performed______________Peak GH Levels ________ Age Reference Range: ______________Date Tested: __________

IGF-1 Level: ________Age Reference Range: ______________Date Tested: ______________

4. 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.

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Additional information to justify medical necessity of GH therapy (i.e. TSH, testosterone, FSH/LH) or attach additional information with form:

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Note: Delivered by Keystone Mercy 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: ______________

If the information requested above is not included with the Growth Hormone request form, this may result in denial due to insufficient information or delays in authorization.