

**Physician Request Form for Patient Self-Administered Growth Hormone**

Fax to Keystone Mercy Pharmacy Services at 215-937-5018, or to speak to a representative call **800-588-6767**. Form must be completed for processing.

Patient's Name: \_\_\_\_\_

Keystone Mercy ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg

Birthdate: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

License #: \_\_\_\_\_

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.

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

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.**