## **GROWTH HORMONE PRE-AUTHORIZATION REQUEST FORM**

## I. General Information

II General Information	
Member and Prescriber information	
Patient card number:	Provider name:
Patient age:	Prescribing physician specialty:
Clinical information	
Clinical information  Is the member currently established on recom	hinant growth hormono/
Somatropin? Yes No	biliant growth normoney
If yes, kindly provide documentation for the in	dications and patient current status
If No, kindly fill the below form.	
· · · · · · · · · · · · · · · · · · ·	
II. Please fill the following secti	on for patients age <18 years old
3	
<b>Medical Assessment And Diagnostic T</b>	esting
Growth Hormone Deficiency (GHD) ICD10	code
A- Laboratory tests*	
1- Growth hormone stimulation test (argi	
	lab
2- IGF-1 and IFG-PB3 test	
- Date	
	er
*Kindly provide a copy of either laboratory tes  B- Please provide evidence of the foll	owing (if applicable)
Neonatal hypoglycaemia	ownig (ii applicable)
	evel
<ul> <li>Reference range as per the testing</li> </ul>	lab
	on
A- Auxologic Criteria**	
- Current height:cmcm	
_	ht below mean for age & gender (+) or (-):
- Father's height cm Mother	's heightcm, mid parental heightcm
- Patient's projected adult height	
- Bone age	
- Growth plate is open Yes 🔲	No 🔲
(IF YES, please attach a confirmate	
<ul> <li>kindly list any other metabolic or g</li> </ul>	genetic disorder (if applicable)
**Please attach any growth chart used for height	ght measurement
Thease accounting growth chart asea for field	ghe measurement

HIV/AIDS wasting syndrome	ICD code and description
Kindly provide the following	
	ercentage from base line

## III. Please fill the following section for patients age >18 years old

Medical Assessment And Diagnostic Testing		
Growth Hormone Deficiency (GHD) ICD10 code		
C- Laboratory tests*		
1- Growth hormone stimulation test (arginine, glucagon, insulin)		
- Date		
- Test value		
- Reference range as per the testing lab		
2- IGF-1 and IFG-PB3 test		
- Date		
- Test value		
- Reference range for age and gender		
*Kindly provide a copy of either laboratory test results		
HIV/AIDS wasting syndrome ICD code and description		
Kindly provide the following		
<ul> <li>Weight loss percentage from base line</li></ul>		