

Nebraska Medicaid Program Request for Prior Authorization of Payment
INSULIN-LIKE GROWTH FACTOR (IGF) FOR CHILDREN

Requested data must be noted on the fax form. Data provided only on attachments is not acceptable.

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME:

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FIRST NAME:

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ID NUMBER:

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DATE OF BIRTH: (Note: patient must be 18 years or younger)

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OTHER INSURANCE INFORMATION/ID#:

Prescriber Information

LAST NAME:

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FIRST NAME:

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NPI NUMBER:

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DEA NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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PHYSICIAN SPECIALTY:

Participating Pharmacy

NAME:

REQUEST DATE

PHONE NUMBER:

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FAX NUMBER:

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Drug/Clinical Information

Initial

Renewal Growth velocity (cm/yr.): Current _____ Pre-Treatment: _____ Compliant with IGF therapy: Yes No
Renewal may be denied for non-compliance with therapy and/or failure to demonstrate a current growth rate at least 2 cm/yr > pre-treatment growth rate.

DRUG REQUESTED

NAME:

STRENGTH:

DAILY DOSE

Primary Diagnosis:

Primary Insulin-Like Growth Factor (IGF-1) Deficiency (IGFD)

Height Standard Deviation Score: _____

Basal IGF-1 Standard Deviation Score: _____

IGF-1 level & reference range _____

Provocative testing: (Initial Request Only)

Agent 1: _____

Peak: _____

Date: _____

Agent 2: _____

Peak: _____

Date: _____

Growth Hormone Gene Deletion with Neutralizing Antibodies to GH

Other: (specify) _____

Date of Most Recent Clinic Visit: _____

Diagnostic Testing (attach **all** results)

Physical Stature Percentile: _____ Height: _____ cm Weight: _____ kg Tanner Stage: _____

Bone Age: _____ Yr. _____ Mo. Chronological Age: _____ Yr. _____ Mo. Date of Scan _____

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Open epiphyses: Yes No

Mother's Height: _____ cm Father's Height: _____ cm Growth Velocity: _____ cm/yr.

Thyroid level & reference range _____ ACTH level & reference range _____

What, if any, hormone replacement therapy, is patient receiving:

Attach growth chart, showing trend over a minimum of the past 3 years.

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. I also attest that I have obtained authorization to release the above information. I will be supervising the patient's treatment.

Prescriber Signature (Required)

Date

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records.)
Please note: The Department may request chart documentation to verify the above information.