

Physician Request Form for Patient Self-Administered Growth Hormone

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041** or urgent requests to **866-533-5497**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-369-6037**. **Form must be completed for processing.**



Patient's Name: _____
Address: _____
City: _____ State: _____
Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg

Plan ID#: _____
Apt # or Suite #: _____
Zip Code: _____
Birth date: _____

Physician's Name: _____
Address: _____
City: _____ State: _____
Contact Person: _____ Phone #: _____
Physician Signature: _____

NPI #: _____
Apt # or Suite #: _____
Zip Code: _____
Fax #: _____
Date: _____

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

Drug Name: _____

Dose: _____

Sig (How Administered): _____

Diagnosis: _____

ICD-9 Diagnosis Code: _____

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

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 PerformRx 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: _____

