

## MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to 1-888-865-6531 R Mail request to: Pharmacy Services Prior Authorization Dep

Reset Form

Print Form

OR Mail request to: Pharmacy Services Prior Authorization Dept.

5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication.

Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

Non-Preferred: Humatrope, Nutropin, Omnitrope, Saizen, Zomacton
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #												Date of Birth (MM/DD/YYYY)																
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Recipient's Full Name																												
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Prescriber's Full Name																	1				1							
Prescriber's NPI																												
Presc	escriber Phone Number											Prescriber Fax Number																
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Drug:	rug: Quantity: Dosage Frequency:																											
Height	:	in or					cn	cm <b>Weight:</b>				lbs or				kg <b>BMI</b>			11:	kg/m²			n <sup>2</sup>					
Date la	Date last seen by the prescribing endocrinologist:																											
Diag	nosis	: (Plea	ase	che	ck a	ll th	at a	pply	and	l sul	bmit	t pro	gres	ss n	otes	.)												
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Recipie	ent's	Full	Nan	ne																				
Date of	Birt	h (M	M/D	D/Y	YYY)				]	<b>,</b>	1			<b>,</b>	•								•	
Fill in a																_								าร)
Growth Velocity: (SD) and _								nd _	(cm/year) Bone A						ge:(year) Height:						(%)			
Growtl			□ eigh		Open				Close er's he		- mot	her's	s heigh	t) ÷ 2	, plus	2.5 ir	ches	(male	e) or r	minus	2.5 in	ches	(fen	nale)]
Providers must correct for Thyroid Stimula  TSH: mU/L Norm										g Hormone (TSH) deficiency prior to co								onducting a stimulation test:  Date:						
Stimula Test (IT			_	•											•	rred s	timula	ation 1	test is	the I	nsulin	Tole	ance	Э
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Test 2:	typ	e				P	eak	GH	Value:				ng/ml	_ Sta	andaı	d Pea	ık:		n	g/mL	Date	:		
Previo	us IC	3F-1	(if a	pplic	able	)			ng/mL	N	orma	al ra	nge (fo	or age	e):						Date	:		
Recen	t IGF	-1:_							ng/mL	N	orma	al ra	nge (fo	or age	e):						Date	:		
Prescriber's Signature:											Date:													
REQUIR copies																		chart	note	s), and	d the n	nost ı	ecer	nt

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