

**2010 MEDICARE PART D  
GROWTH HORMONE  
PHYSICIAN FAX FORM**



**ONLY the prescriber may complete this form. This form is for Medicare Part D requests.**

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit [www.myrxassistant.com](http://www.myrxassistant.com) and search for the appropriate health plan formulary.

Today's Date: \_\_\_\_\_

**PATIENT, INSURANCE and PHYSICIAN/CLINIC INFORMATION**

Patient Name (First):		Last:		M:	DOB (mm/dd/yy):
Insurance ID Number:			Patient Telephone Number:		
Prescriber Name:	Physician NPI#:		Specialty:	Clinic Contact Person's Name:	
Clinic Name:			Clinic Address:		
City, State, Zip:			Clinic Phone #:	Clinic Secure Fax #:	
Is the patient a long term care facility resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the LTC facility contact's name, telephone and fax numbers					
LTC Contact Name:		LTC Phone #:		LTC Secure Fax #:	

<b>Patient's Diagnosis</b> ICD-9 code plus description:	<b>Date of Diagnosis:</b>
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**Medication Requested:**

**Information Required for ALL PATIENTS:**

- Please list all reasons for selecting the requested **medication** over alternative GH products (e.g. adverse reaction to other GH products.) \_\_\_\_\_
- How often will the patient be seen for follow-up? \_\_\_\_\_ Date last seen: \_\_\_\_\_
- Date GH treatment started: \_\_\_\_\_

<b>Growth Hormone Stim Tests are required for ALL PATIENTS:</b> (1 for adults, 2 for children) Agent 1:                      Peak:  Agent 2:                      Peak:	<b>Additional Lab Tests Performed:</b> (e.g. IGF-1, TSH)		
	Test:	Result:	Date:
	Test:	Result:	Date:
Test:	Result:	Date:	

**Information Required FOR CHILDREN:**

Ht (cm) at diagnosis: \_\_\_\_\_ Ht SD below the mean at diagnosis: \_\_\_\_\_ Growth Velocity (cm/yr) at diagnosis: \_\_\_\_\_

If the patient has been on GH therapy for 6 months or longer, has the patient's height increased or growth velocity improved since the last evaluation? .....  Yes  No

**Information Required FOR ADULTS:**

- Does the patient have evidence of hypothalamic-pituitary injury? .....  Yes  No
- Does the patient have a medical history of childhood GH deficiency or isolated GH deficiency? .....  Yes  No  
If yes, has the patient been reevaluated as an adult to confirm the diagnosis of GH deficiency? .....  Yes  No
- Has the patient been on the GH therapy for 6 months or longer? .....  Yes  No  
If yes, has the serum IGF-1 level been reevaluated? .....  Yes  No  
**And**, has the patient improved since the start of GH therapy in any of the following areas: body composition, cardiovascular health, bone mineral density, serum cholesterol, physical strength or quality of life? .....  Yes  No

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 1305 Corporate Center Drive  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax:** 800.693.6703      **Phone:** 800.693.6651

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