



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE- GROWTH HORMONE

M.D. Last Name: _____ M.D. First Name: _____

Physician Phone: _____ Physician Fax: _____

Patient _____ ID# _____ DOB _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS. ADDITIONALLY, AN ENDOCRINOLOGY CONSULT, GROWTH CHARTS, MRI RESULTS, LAB RESULTS AND ALL OTHER SUPPORTIVE DOCUMENTATION ARE REQUIRED FOR EVALUATION OF THIS REQUEST.

1. Product Requested _____
2. Dose Requested : _____ mg/Kg/week **OR** _____ mg/day _____ days/week
3. Patient Current Height (in centimeters): _____ CM
4. Patient Current Weight (in kilograms): _____ KG
5. If member is 17 years of age or younger, please indicate patient's diagnosis (if 18 or older, SKIP to #8):
 - Growth Hormone Deficiency
 - Small for Gestational Age
 - Idiopathic Short Stature
 - Prader-Willi Syndrome
 - Turner Syndrome
 - SHOX deficiency
 - Chronic renal insufficiency
 - Other diagnosis: _____

Note: If other diagnosis is used, please attach a study with efficacy data supporting this request
6. Are the patient's epiphyses open? Yes No
7. Has the patient started puberty? Yes No
8. Adult patient diagnosis:
 - Childhood onset growth hormone deficiency
 - GH deficiency resulting from hypothalamic/pituitary disease or surgery
 - GH deficiency resulting from cranial radiation
 - AIDS related cachexia (SEROSTIM ONLY)
 - HIV lipodystrophy (SEROSTIM ONLY)
 - Short Bowel Syndrome (ZORBTIVE ONLY)
 - Other diagnosis: _____

Note: If other diagnosis is used, please attach a study with efficacy data supporting this request

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
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QUESTIONS PLEASE CALL:
877-526-9906