Children's Physicians Medical Group
in partnership with Rady Children's Health Network

Growth Hormone – Initial Authorization

Please complete this form, attach supporting clinical documentation, and fax to CPMG at 858-309-7977, or upload to authorization submission via EZ-Net. Failure to provide this form may result in a delay in processing of your request.

Referring Provider: _____ **Provider Contact Phone #:** _____

Member Name: _____ **Member ID #:** _____

Member DOB: _____ **Member Age:** _____ **Member Health Plan:** _____

Rendering Vendor: _____ **Diagnosis Code (ICD-10):** _____

CPT Code(s): _____

FOR ALL MEMBERS:

☐ Height _____ cm = _____ SD's below mean

What is the mid-parental height? _____ cm

☐ Open bone epiphysis (X-Ray date: _____)

☐ GH deficiency (failure to produce GH value of greater than or equal to 10 mcg/L following 2 standard tests)

Tests completed:

- ☐ Insulin
- ☐ Arginine plus GHRH
- ☐ L-arginine
- ☐ Clonidine
- ☐ Glucagon
- ☐ Propranolol
- ☐ Other, please specify _____

☐ Growth Velocity is below normal, specify % over 1 year: _____

FOR MEMBERS WITH SPECIFIED DIAGNOSES:

☐ Member has been diagnosed with Prader-Willi Syndrome – confirmed by genetic testing.
☐ Member has been diagnosed with Turner's Syndrome – confirmed by chromosome analysis.
☐ Member has been diagnosed with Chronic Renal Insufficiency and is at least 1 year post-transplant.
☐ Member has been diagnosed with SGA or IUGR AND has one of the following (attach growth curves from birth through present):

- ☐ Failed to manifest catch up growth by age 2
- ☐ Failed to manifest catch up growth by age 3

FOR MEMBERS WITH IDIOPATHIC SHORT STATURE:

☐ Member has a delayed bone age at more than 18 months
☐ Member is -2.5 SD below the mean in height for age
☐ Member has growth rate less than 5 cm/year, or less than the 10th percentile in velocity for age, documented over at least a one year period.