MEDICA®

Medication Request Form (MRF)
Growth Hormone
c/o MedImpact Healthcare Systems, Inc.

Please complete this form and FAX to:	*Or to call in this information to:*	*Questions call:*
MedImpact HealthCare Systems, Inc. Attn: Prior Authorization Department **1-858-790-7100 FAX**	MedImpact HealthCare Systems, Inc. Attn: Prior Authorization Department **1-800-788-2949**	MedImpact HealthCare Systems, Inc. Attn: Customer Service Department **1-800-788-2949**

Please complete the following information – REQUIRED – ALL WHITE BOXES (Those not highlighted in gray) MUST BE COMPLETED or the form will be returned to the sender. Please complete all boxes if possible.

Patient Name:		Physician Name and Specialty:
Patient ID:		Physician DEA #:
Patient DOB: / /	Patient Phone #: ( ) -	Physician: Address: City, State, ZIP: ,
Diagnosis:		Physician Phone Number and Area Code: ( ) -
Drug Requested:		Physician Fax Number and Area Code: ( ) -
Dosage, Quantity Requested (per month) and Length of Treatment (please be specific):		Pharmacy Name, Phone Number and Area Code: ( ) —

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1. Is the prescriber an endocrinologist?..... Blank
2. Does the patient have AIDS-related cachexia/wasting syndrome. (if yes, answer a to g below)..... Blank
3. Please answer all that apply:
   a) 10% unintentional weight loss over 12 months Blank
   b) 7.5% unintentional weight loss over 6 months Blank
   c) 5% body cell mass (BCM) loss within 6 months Blank
   d) In men: BCM<35% of total body weight and BMI <27kg/m^2 Blank
   e) In women: BCM<23% of total body weight and BMI<27kg/m^2 Blank
   f) List drugs that have been tried to treat this condition:
   g) If this is a renewal, please indicate weight gain per month: kg/month or .lbs/month
4. Is the patient less than 18 years old (if yes, please answer a to d below)..... Blank
   a). What is the patient's bone age?
   b) Is there evidence of non-closure of the epiphyseal plate as confirmed by x-ray of wrist/Hand?..... Blank
   c) Is the patient diagnosed with Small for gestational age defined as birth weight of less than 2.5kg at a gestational age of 37 weeks, or birth length or weight below the 3rd percentile for gestational age..... Blank
   d) Does the patient have Turner's Syndrome/Noonan Syndrome/Prader Willi-Syndrome?
   (Please fax genetic testing results) ..... Blank
3. Does the patient have a lack of response to growth hormone stimulation tests, or an IGF-1 that is –2 SD below the normal range for age and sex, or an IGFBG-3 level that is –2 SD below the normal range for age and sex? **(Please fax documentation)** ..... Blank
4. Does the patient have growth hormone deficiency that is idiopathic in nature AND the patient has a lack of response to growth hormone stimulation tests, or an IGF-1 that is –2 DS below the normal range for age and sex, or an IGFBG-3 level that is –2 SD below the normal range for age and sex? **(Please fax documentation)**..... Blank
5. Does the patient have Lack of response to growth hormone stimulation tests to at least two stimuli (insulin, levodopa, arginine, clonidine, sinemet or glucagon)? **(Please fax documentation)**..... Blank
6. Does the patient have growth hormone deficiency that is from an organic cause?..... Blank
7. If this is a request for renewal of growth hormone therapy, has the patient's growth velocity increased by at least 2 cm/year **(Please fax documentation)** ..... Blank
8. If this request is for Zorbtive, does the patient have short bowel syndrome and is currently receiving specialized nutritional support?..... Blank

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