

# Bluegrass Family Health

## Medication Pre-Certification Request for Growth Hormones

Phone: 877-205-6308

Fax: 859-335-3744

Instructions: This form is to be used by physicians and providers to request approval for medications requiring pre-certification (Pre-cert). Approval is based on medical necessity criteria established by the Bluegrass Family Health's Pharmacy and Therapeutics Committee. Please complete this form in detail and fax to 859-335-3744. **Requests lacking pertinent information will be denied pending additional information. For this reason, office notes may be required.**

### MEMBER INFO:

Name: \_\_\_\_\_ ID Number: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis **and Code**: \_\_\_\_\_

Drug Requested: \_\_\_\_\_ Strength \_\_\_\_\_ **JCODE** \_\_\_\_\_

Length of Treatment: \_\_\_\_\_ Quantity: \_\_\_\_\_ Dosage Form: Oral / Injection / Topical



*Please submit evidence of Growth Hormone (GH) Deficiency including serum concentrations produced by 2 pharmacologic stimulation tests, hormone evidence of hypopituitarism and low GH, or documented presence of at least 3 other pituitary hormone deficiencies. If being used for other purposes, please submit documentation proving medical necessity.*

Medication History, including medications tried and failed (please include strength and dose of each): \_\_\_\_\_

Other Pertinent History: \_\_\_\_\_

### PROVIDER INFO:

Will the doctor be providing this medication? YES / NO

Will this be administered at the provider office? YES / NO

Physician Name and Specialty: \_\_\_\_\_

DEA# \_\_\_\_\_ Contact Person (Please Print): \_\_\_\_\_

Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Signature of Contact Person: \_\_\_\_\_

### *BFH USE ONLY:*

Request was: Approved Qty approved: \_\_\_\_\_ Denied Pending More Info

Specialist Initials: \_\_\_\_\_ Start Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Referral #: \_\_\_\_\_

Comments: \_\_\_\_\_