PA06 - GROWTH HORMONES
NOT required for recipients less than 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
Gainwell Technologies ATTN: PHARMACIST
301 Metro Center Blvd., 3rd Floor ▪ Warwick, RI 02886 ▪ FAX (401) 784-3889

CLIENT NAME: ____ DOB: ____/___/_____ MEDICAID ID NUMBER: _________________________

PRESCRIBER NAME: ____PRESCRIBER NPI #: ______________________________

PRESCRIBER OFFICE ADDRESS: ____

____

OFFICE PHONE NUMBER (   ) _________________________ FAX NUMBER (   ) _________________________

DRUG REQUESTED: ____ QTY / FILL __________

INDICATE THE RELEVANT DIAGNOSIS WITH APPROPRIATE ICD10 CODE.

___ DOES THE PATIENT HAVE A DIAGNOSIS OF GH DEFICIENCY? ICD10 CODE__________

DUE TO:____

OR

___DOES THE PATIENT HAVE A DIAGNOIS OF CHILDHOOD ONSET? ICD10 CODE__________
GH DEFICIENT DURING CHILDHOOD AND CONFIRMED GH DEFICIENT AS AN ADULT PRIOR TO REPLACEMENT THERAPY.

ONE OF THE ABOVE AND THE FOLLOWING MUST BE DOCUMENTED FOR APPROVAL.

___DOES THE PATIENT HAVE A BIOCHEMICAL DIAGNOSIS OF GH DEFICIENTY BY MEANS OF NEGATIVE RESPONSE TO GH STIMULATION TEST? (E.G. ARGINNE STIMULATION TEST) [Y/N]

COMMENTS: ____

____

____

____

PRESCRIBER SIGNATURE ____**DATE** ____________________

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT GAINWELL TECHNOLOGIES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100

FOR STATE USE ONLY:

APPROVAL: ______YES ______NO PRIOR AUTHORIZATION #: _________________________

EFFECTIVE DATES: FROM: _____________________________TO __________________________

Revised 10.2020