



Growth Hormone Statement of Medical Necessity

Prescriber: Please complete *Patient*, and *Clinical Information* sections and **FAX to 952-853-8700 or 1-888-883-5434** Incomplete submissions will be returned and may delay review. For questions please **call 952-883-5813 or 800-492-7259**

Patient	Last Name		First	MI
	Date of Birth		HealthPartners ID #	
	Patient Address			
	Parent / Guardian Name(s)		Telephone #	
Clinical Information	Provider / Prescriber Details			
	Provider Name (FIRST and LAST)		Clinic Address	
	Telephone #		Fax #	
	Requested Therapy			
	Drug Requested	Norditropin	Other	Dose / Frequency
	<small>If Other provide reason in medical history</small>			
	Date therapy initiated		Estimated duration of therapy	
	Diagnostic Details			
	Current Height		Current Weight	
	Height Percentile at Time of Diagnosis		Weight Percentile at Time of Diagnosis	
	Bone Age		Date of Measurement	
	Complete Diagnosis (including Karyotype of Turner's)			
	Tanner Stages: Genital/Breast		Pubic Hair	Axillary Hair
	Pertinent medical history (please include growth pattern, diagnostic test, treatment plan and response to therapy) <i>Can be sent on a separate document.</i>			
	Growth Velocity - Please provide actual heights and dates of measurements. Please attach growth chart.			
	Pretreatment growth velocity		Current growth velocity over the last 12 months	
	Date	Height	Date	Height
	Date of Stim test		Type of Stim test used	
	PK GH value on Stim test		Original test results <i>(Please attach copy)</i>	
Provider Certification				
This is a request for: Initial Certification Recertification				
Physician's Signature:			Date:	

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