

Growth Hormone Injection Prior Authorization Form



**ROCKY MOUNTAIN
HEALTH PLANS®**

We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

Diagnosis:	Patient under 21 years old? <input type="checkbox"/> Yes <input type="checkbox"/> No Medical director must review for adult patients
	History of growth failure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required):
	Please attach a copy of the prescription or provide ALL of the information below: Medication _____ Strength _____ Sig _____ Qty _____ Refills _____
	Please attach all relevant medical records and test results. Incomplete forms will not be processed.

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP
3

Prescriber Signature _____
Date

STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
970-248-5034

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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