HealthPartners®

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 *If Other provide reason in medical history*	Dose / Frequency
	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) *Can be sent on a separate document.*	
	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 (*Please attach copy*)
	Provider Certification	
	This is a request for: Initial Certification Recertification	
	Physician's Signature:	Date: