

TEXAS HEALTH AND HUMAN SERVICES COMMISSION  
TEXAS MEDICAID/CHIP VENDOR DRUG PROGRAM

*Children with Special Health Care Needs (CSHCN) Services Program*  
**Growth Hormone Approval Request Form**

Complete all items or the form will be returned for additional information.  
Please document reason why any information is not available.

<b>Client Name:</b> _____	<b>CSHCN ID#:</b> _____
<b>Address:</b> _____	<b>Date of Birth:</b> _____
_____	<b>Gender:</b> _____
_____	<b>Dosage:</b> _____
<b>Indicate Insurance coverage (if any):</b> _____ Private _____ Medicaid _____ None	

**Client's diagnosis (ICD-9):** \_\_\_\_\_

- Name of growth hormone: \_\_\_\_\_ Dose: \_\_\_\_\_  
Frequency of administration: \_\_\_\_\_ Weight: \_\_\_\_\_
- Growth velocity (submit updated growth chart including growth in the previous 3 years):  
Before GH therapy: \_\_\_\_\_ CM/YR  
After GH therapy: \_\_\_\_\_ CM/YR
- Date started on GH therapy: \_\_\_\_\_
- Has treatment been continuous? \_\_\_\_\_ Yes \_\_\_\_\_ No (if no, explain why therapy was interrupted):  
\_\_\_\_\_  
Epiphysis are open? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Physician has seen Bone Age (B.A.) within prior 12 months: \_\_\_\_\_ Yes \_\_\_\_\_ No  
B.A. male > 16: \_\_\_\_\_ Yes \_\_\_\_\_ No  
B.A. female > 14: \_\_\_\_\_ Yes \_\_\_\_\_ No  
If B.A. not done in last 12 months, date and result of most recent bone age: \_\_\_\_\_
- Thyroid function normal? \_\_\_\_\_ Yes \_\_\_\_\_ No
- On replacement therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No
- IGF/BP3 result (if done): \_\_\_\_\_
- Peak growth hormone level ng/ml (must have two stimulation tests or one test with two provocative agent)  
Provocative agent(s) 1. \_\_\_\_\_ Peak \_\_\_\_\_ ng/ml  
2. \_\_\_\_\_ Peak \_\_\_\_\_ ng/ml

(A chromosomal analysis documenting XO karyotype can be submitted in lieu of provocative stimulation tests)

**PHYSICIAN SECTION MUST BE COMPLETED**

<b>Name:</b> _____	<b>Tx. License #:</b> _____
<b>Address:</b> _____	<b>Phone:</b> _____
_____	<b>Fax:</b> _____

To the best of my knowledge, this child has no active brain tumor, all other pituitary function has been assessed and is normal (or pituitary deficiencies are appropriately treated), and this treatment is not part of a research protocol.

<b>Physician Signature:</b> _____	<b>Date</b> _____
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**FORM SUBMITTAL INSTRUCTIONS**

Drug Use Review (H-630)  
HHSC Medicaid/CHIP Vendor Drug Program  
PO Box 85200, Austin, Texas 78708-5200  
Fax: 512-491-1962