NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

NC DHB Pharmacy Request for Prior Approval - Growth Hormone
Adult 21 Years of Age and Older

Recipient Information **DMA-0016 (V.01)**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information: Name:_____ Phone #:_____Ext:_____

Drug Information

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐Other:_____

Clinical Information

1. Diagnosis:

_____

FOR NON-PREFERRED DRUGS: COMPLETE THIS SECTION AS WELL AS BELOW.

☐ Failed two preferred drug(s). List preferred drugs failed - *or* - list reason why patient cannot try two preferred drugs: (Specify)

_____

_____

2. History of:
a. ☐ Turners Syndrome b. ☐ Prader Willi Syndrome c. ☐ Craniopharyngioma
d. ☐ Panhypopituitarism e. ☐ Cranial Irradiation
f. ☐ MRI History of Hypopituitarism list:_____
g. ☐ Hypopituitarism h. ☐ Chronic Renal Insufficiency i. ☐ SGA with IUGR
j. ☐ Other: _____

3. Was the patient diagnosed as a child? ☐ Yes ☐ No
4. Did the patient have a height velocity <25th Percentile for Bone Age? ☐Yes ☐No Height Velocity:_____
5. Did the patient have low serum levels of IGF-1 and IGFBP-3? ☐Yes ☐No
(IGF-1) Level:_____ (IGFBP-3) Level: _____

6. Did the patient have other signs of hypopituitarism? ☐Yes ☐No
List: _____

7. Was the patient an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia? ☐ Yes ☐ No

8. Was the patient's height < 3rd percentile for chronological age? ☐ Yes ☐ No

Height: _____ Percentile: _____

9. Was birth weight and/or length more than 2 standard deviations below mean for gestational age with no catch up by age 2? ☐ Yes ☐ No

10. Is the patient currently being treated and diagnosed with GHD in childhood with a current low IGF-1? ☐ Yes ☐ No (IGF-1) Level: _____

11. Is the patient currently being treated and diagnosed with short stature in childhood with height > 2.25 standard deviations below mean for age, and bone age > 2 standard deviations below mean, and low serum levels of IGF-1 and IGF-BP3? ☐ Yes ☐ No (IGF-1) Level: _____ (IGF-BP3) Level: _____

12. IS GHD documented by a negative response to a GH stimulation test? ☐ Yes ☐ No
Agent 1: ____ Agent 2: _____ Peak: _____ Ng/ml: _____

13. Document cause of GHD (pituitary/hypothalamic disease, radiation, surgery, trauma):

_____

_____

Zorbitive only: 14. Is there a history of short bowel syndrome in the last 2 years? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**