



**NC Medicaid
Pharmacy Prior Approval Request for
Hormonal Products for Beneficiaries Under 18 Years of Age**

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days Other _____

Clinical Information

Requests for Hormonal Products:

1. Is the beneficiary under 18 years of age? Yes No

2. Is this medication being prescribed for gender affirming care? Yes No 2a. Was the medication initiated PRIOR to August 1, 2023? Yes No
Date initiated: _____

**** Please note: Coverage **cannot** be provided for beneficiaries under 18 years of age as a puberty blocker for gender affirming care unless the medication for gender affirming care was initiated PRIOR to August 1, 2023.****

3. For beneficiaries under 18 years of age, please check the medication being prescribed and beneficiary's diagnosis.

A) Zoladex (goserelin) Yes No

1) Carcinoma of prostate (management and palliative)

2) Endometriosis

3) Endometrial-thinning prior to endometrial ablation for dysfunctional uterine bleeding

4) Palliative treatment of advanced breast cancer

5) Breast cancer treatment

6) Ovarian preservation during chemotherapy treatment

7) Other: _____

B) Supprelin (histrelin) Yes No

1) Central precocious puberty

2) Prostate cancer

3) Other: _____

C) Leuprolide Yes No

1) Prostate cancer

2) Central precocious puberty

3) Endometriosis

4) Anemia caused by uterine fibroids

5) Breast cancer (ovarian suppression)

6) Other: _____

D) Triptodur (triptorelin) Yes No

1) Central precocious puberty

2) Prostate cancer

3) Breast cancer-ovarian suppression

4) Other: _____

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