WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Growth Hormone – Adult 21 Years of Age and Older

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

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: _____
2. History of: ☐ Turner syndrome ☐ Prader Willi syndrome ☐ Craniopharyngioma
☐ Panhypopituitarism ☐ Cranial Irradiation ☐ MRI History of Hypopituitarism list: ☐ Hypopituitarism
☐ Chronic Renal Insufficiency ☐ SGA with IUGR ☐ 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 past 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 **1-800-678-3189** Pharmacy PA Call Center: **1-866-799-5318**