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.

2. ☐ Failed two preferred drug(s). List preferred drugs failed: ____
   2b. Or list reason why patient cannot try two preferred drugs: ____
3. History of: ☐ Turners Syndrome ☐ Prader Willi Syndrome ☐ Craniopharyngioma
   ☐ Panhypopituitarism ☐ Cranial Irradiation ☐ MRI History of Hypopituitarism list: _________________________
   ☐ Hypopituitarism ☐ Chronic Renal Insufficiency ☐ SGA with IUGR
   ☐ Other: _________________________________
4. Was the patient diagnosed as a child? ☐ **Yes** ☐ **No**
5. Did the patient have a height velocity < 25th Percentile for Bone Age. ☐ **Yes** ☐ **No** Height Velocity: ______________________
6. Did the patient have low serum levels of IGF-1 and IGFBP-3? ☐ **Yes** ☐ **No** IGF-1 Level: IGFBP-3 Level: _________________
7. Did the patient have other signs of hypopituitarism? ☐ **Yes** ☐ **No** List: ____
8. Was the patient an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia? ☐ **Yes** ☐ **No**
9. Was the patient's height < 3rd percentile for chronological age? ☐ **Yes** ☐ **No** Height: ___________ Percentile: _____________
10. 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**
11. Is the patient currently being treated and diagnosed with GHD in childhood with a current low IGF-1? ☐ **Yes** ☐ **No**
    IGF-1 Level: _________________
12. 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: _______________
13. IS GHD documented by a negative response to a GH stimulation test? ☐ **Yes** ☐ **No** Agent 1: _________ Agent 2: _________
    Peak: ___________ Ng/ml
14. Document cause of GHD (pituitary/hypothalamic disease, radiation, surgery, trauma): ________________________________

Zorbitive only:

15. 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 CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505