carolina complete health

Pharmacy Request for Prior Approval - Growth Hormone – Children Less than 21 Years of Age

Recipient Information

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: _____
2. History of: a. ☐ Turners Syndrome b. ☐ Prader Willi Syndrome c. ☐ Craniopharyngioma in the last 2 years
d. ☐ Panhypopituitarism in the last 2 years e. ☐ Cranial Irradiation in the last 2 years
f. ☐ MRI Evidence of Hypopituitarism List: _____ g. ☐ Hypopituitarism
h. ☐ Chronic Renal Insufficiency in the last 2 years i. ☐ SGA with IUGR j. ☐ Other: _____
3. Please check all that apply:
a. ☐ Patient has a height velocity < 25th Percentile for Bone Age. Height Velocity: _____
b. ☐ Patient has low serum levels of IGF-1 and IGFBP-3 IGF-1 Level: _____ IGFBP-3 Level: _____
c. ☐ Patient has other signs of hypopituitarism List: _____
d. ☐ Patient is an adequately nourished child with hypoglycemia and a low GH response to hypoglycemia
e. ☐ Patient's height is < 3rd percentile for chronological age Height: _____ Percentile: _____
f. ☐ Birth weight and/or length more than 2 standard deviations below mean for gestational age with no catch up by age 2.
g. ☐ History of GHD in the last 2 years. Is there a genetic cause? _____
Stim testing? Agent 1: ____ Agent 2: _____ Peak: _____ Ng/ml: _____
3. Is the epiphysis open (if patient > 9 years old)? ☐ Yes ☐ No
4. Is the patient diagnosed with unexplained short statue 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 IGFBP-3? ☐ Yes ☐ No IGF-1 Level: ___IGFBP-3 Level: ____
5. Is the patient currently being treated? ☐ Yes ☐ No
6a. Growth rate over previous year: _____ b. Has the patient entered puberty? ☐ Yes ☐ No
7. Are IGF-1 and IGF-BP3 within age appropriate range? ☐ Yes ☐ No Results: _____
Zorbitive only: 8. Is there a history of short bowel syndrome in the last 2 years? ☐ Yes ☐ No
Increlex only: Check all that apply
9a. ☐ History of GH product in last year b. ☐ GH resistance is caused by mutation in GH receptor of post GH receptor signaling pathway
c. ☐ Patient has IGF-1 gene defects d. ☐ GH gene deletions and patient has developed neutralizing antibodies to GH
e. ☐ Patient ht < 3 SD < mean and IGF-1 level < 3 SD < Mean and normal or elevated GH levels.

Signature of Prescriber:_____ Date:_____

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: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309