



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

Recipient Information

DMA-0017 (V.03)

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 stature 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 or 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: _____

*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 CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505