



NC DHB Pharmacy Request for Prior Approval - Growth Hormone Adult 21 Years of Age and Older

Recipient Information

DMA-0016 (V.01)

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 #: 9. Requester Contact Information: Name: Phone #: Ext:

Drug Information

9a. Drug Name: 9b. Is this request for a Non-Preferred Drug? 10. Strength: 11. Quantity Per 30 Days: 12. Length of Therapy (in 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: (Specify)

2. History of:

- a. Turners Syndrome b. Prader Willi Syndrome c. Craniopharyngioma d. Panhypopituitarism e. Cranial Irradiation f. MRI History of Hypopituitarism list: g. Hypopituitarism h. Chronic Renal Insufficiency i. SGA with IUGR j. Other:

3. Was the patient diagnosed as a child? 4. Did the patient have a height velocity <25th Percentile for Bone Age? Height Velocity: 5. Did the patient have low serum levels of IGF-1 and IGFBP-3? (IGF-1) Level: (IGFBP-3) Level:

6. Did the patient have other signs of hypopituitarism? 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 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: (800) 678-3189

Pharmacy PA Call Center: (866) 799-5318