WellCare

NC Medicaid
Pharmacy Prior Approval Request for
Hormonal Products for Beneficiaries Under 18 Years of Age

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 ☐ Other _____

Clinical Information

Requests for Hormonal Products:

1. Is the beneficiary under 18 years of age? ☐ Yes ☐ No
2. Is this medication being prescribed for gender affirming care? ☐ Yes ☐ No 2a. Was the medication initiated PRIOR to August 1, 2023? ☐ Yes ☐ No
   Date initiated: _____
   ** Please note: Coverage **cannot** be provided for beneficiaries under 18 years of age as a puberty blocker for gender affirming care unless the medication for gender affirming care was initiated PRIOR to August 1, 2023.**

3. For beneficiaries under 18 years of age, please check the medication being prescribed and beneficiary's diagnosis.
   A) Zoladex (goserelin) ☐ Yes ☐ No
      1) Carcinoma of prostate (management and palliative) ☐
      2) Endometriosis ☐
      3) Endometrial-thinning prior to endometrial ablation for dysfunctional uterine bleeding ☐
      4) Palliative treatment of advanced breast cancer ☐
      5) Breast cancer treatment ☐
      6) Ovarian preservation during chemotherapy treatment ☐
      7) Other: _____

   B) Supprelin (histrelin) ☐ Yes ☐ No
      1) Central precocious puberty ☐
      2) Prostate cancer ☐
      3) Other: _____

   C) Leuprolide ☐ Yes ☐ No
      1) Prostate cancer ☐
      2) Central precocious puberty ☐
      3) Endometriosis ☐
      4) Anemia caused by uterine fibroids ☐
      5) Breast cancer (ovarian suppression) ☐
      6) Other: _____

   D) Triptodur (triptorelin) ☐ Yes ☐ No
      1) Central precocious puberty ☐
      2) Prostate cancer ☐
      3) Breast cancer-ovarian suppression ☐
      4) Other: _____

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.

Pharmacy PA Call Center: (866) 246-8505

Fax this form to CSRA at (855) 710-1969

DHB Pharmacy 116
08.01.2023