AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – 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

7. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
8. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___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 cause by uterine fibroids ☐
      5) Breast cancer (ovarian suppression) ☐
      6) Other: _____
   D) Triptodur (triptorelin) Yes___ No___
      1) Prostate cancer ☐
      2) Central precocious puberty ☐
      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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406