OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Drug Requested (select drug below)**:**	
❑ **INCRELEX®** (mecasermin)	❑ **iPlex®** (mecasermin rinfabate/pf)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable**: _____

CLINICAL CRITERIA: **ALL** appropriate boxes **must** be checked to qualify or authorization process will be delayed. Chart and progress notes **MUST** be attached to this request.

Diagnoses

❑ Severe primary insulin-like growth factor-1 (IGF-1) deficiency	❑ Growth hormone gene deletion	❑ Other (please specify): _____

Clinical Information

Pre-treatment height:_____		**Pre treatment age:**_____	
Pretreatment IGF-1 value (normal range _____) (Less than or equal to 3 standard deviations below the mean for age and gender)		Pretreatment Growth Hormone Level (normal range _____) (Normal or elevated growth hormone levels)	
Date: _____	**Value**: _____	**Date**: _____	**Value:** _____

❑ **For diagnosis Growth hormone gene deletion:**

❑ Neutralizing antibodies to GH ❑ Yes ❑ No ❑ DATE: _____

Criteria for Continuation of Therapy: Approval is for 12 months

❑ If 16 years old or older, provide yearly appropriate document of epiphyses not close

❑ Growth rate velocity must be equal to or greater than 2.5cm/year

(Continued on next page; signature page MUST be attached to this request.)

(Signature page MUST be attached with this request.)

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/26/2017;~~ **8/22/2018**