OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. Authorization process will be delayed if incomplete.***

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:**_____	
Pre treatment IGF-1 value (normal range _____) ***(Less than or equal to 3 standard deviations below the mean for age and gender)***		***Pre treatment 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

*****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**