

OPTIMA HEALTH PLAN

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):

<input type="checkbox"/> INCRELEX® (mecasermin)	<input type="checkbox"/> iPlex® (mecasermin rinfabate/pf)
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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:

<input type="checkbox"/> Severe primary insulin-like growth factor-1 (IGF-1) deficiency	<input type="checkbox"/> Growth hormone gene deletion	<input type="checkbox"/> Other (please specify)
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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 #: _____

* Approved by Pharmacy and Therapeutics Committee: 4/15/17/2013

REVISED/UPDATED: 6/14/13; 4/7/2014; 10/20/2014; 11/6/2014; 5/21/2015; 12/28/2015; 12/19/2016 9/21/2017.