Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Increlex® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Growth hormone gene deletion
❑ Severe primary insulin-like growth factor-1 (IGF-1) deficiency
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is this request for continuation of therapy? ❑ **Yes** ❑ **No**

Is there documentation the patient has had annual bone radiograph to confirm the patient has open epiphyses? ❑ **Yes** ❑ **No**
Appropriate documentation must be provided

Document patient's pre-treatment height: _____

Document patient's pre-treatment age: _____

For growth hormone gene deletion, also answer the following:

Please provide pre-treatment growth hormone level, including the provider's laboratory reference values:

Pre-treatment growth hormone level: _____ Reference values: _____ Date taken: _____
Pre-treatment growth hormone level and normal range must be provided

Has the patient developed neutralizing antibodies to growth hormone? ❑ **Yes** ❑ **No**

For severe primary insulin-like growth factor-1 (IGF-1) deficiency, also answer the following:

Does the patient have pre-treatment IGF-1 value less than or equal to 3 standard deviations below the mean for age and gender? ❑ **Yes** ❑ **No**

Please provide pre-treatment IGF-1 level, including the provider's laboratory reference values:

Pre-treatment IGF-1 level: _____ Reference values: _____ Date taken: _____
Pre-treatment IGF-1 value and normal range must be provided

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.