

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

INCRELEX®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: Increlex® (mecasermin rDNA origin)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
INSULIN-LIKE GROWTH HORMONE FACTOR-1 DEFICIENCY			
1. Does the member have a diagnosis of growth failure with severe primary insulin-like growth factor-1 deficiency (IGFD)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member between the ages of 2-17?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Is the member's basal insulin-like growth factor-1 (IGF-1) standard deviation score less than or equal to -3.0 for age and sex?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Is the member's height standard deviation score less than or equal to -3.0 for age and sex?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
7. Does the member have normal or elevated growth hormone of greater than 10 ng/mL or basal serum growth hormone level greater than 5 ng/mL?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
GROWTH HORMONE GENE DELETION			
1. Does the member have growth failure with growth hormone gene deletion and has developed neutralizing antibodies to growth hormone?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member between the ages of 2-17?	<input type="checkbox"/>	<input type="checkbox"/>	

3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member experienced a growth velocity of ≥ 2 cm total growth in 1 year?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member reached final adult height?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-CHIP-036
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

Confidentiality Notice

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.