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)?	☐	☐	**Please provide documentation**
2. Is the member between the ages of 2-17?	☐	☐	
3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	☐	☐	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	☐	☐	**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?	☐	☐	**Please provide documentation**
6. Is the member's height standard deviation score less than or equal to -3.0 for age and sex?	☐	☐	**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?	☐	☐	**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?	☐	☐	**Please provide documentation**
2. Is the member between the ages of 2-17?	☐	☐	

3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	☐	☐	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	☐	☐	**Please provide documentation**
3. Has the member experienced a growth velocity of ≥2 cm total growth in 1 year?	☐	☐	**Please provide documentation**
4. Has the member reached final adult height?	☐	☐	**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:

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Policy: PHARM-CHIP-036
Origination Date: 07/01/2024
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024