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	e: Member Name:	Member Name:		ID#:			
DOE	B: Gender:	Gender:		Physician:			
Offi	ce Phone: Office Fax:	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 HORMO						
1.	Does the member have a diagnosis of growth failure with springer insuling like growth factor 1 deficiency (ICED)?	severe			Please provide documentation		
2	primary insulin-like growth factor-1 deficiency (IGFD)? Is the member between the ages of 2-17?						
	Is the requesting provider a pediatric endocrinologist or in	1					
<u>.</u>	consultation with one?						
4.	If 15 years of age or older, does the member have open gr plates confirmed by radiographic imaging?	owth			Please provide documentation		
	Is the member's basal insulin-like growth factor-1 (IGF-1) standard deviation score less than or equal to -3.0 for age sex?				Please provide documentation		
6.	Is the member's height standard deviation score less than equal to -3.0 for age and sex?	or			Please provide documentation		
7.	Does the member have normal or elevated growth hormogreater than 10 ng/mL or basal serum growth hormone lever greater than 5 ng/mL?	vel			Please provide documentation		
GROWTH HORMONE GENE DELETION							
1.	Does the member have growth failure with growth hormo gene deletion and has developed neutralizing antibodies t 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			
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: 08/29/2024 Next Review Date: 08/29/2025 Current Effective Date: 09/01/2024

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.