FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Increlex® Coverage Determination 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:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Growth hormone gene deletion
❑ Severe primary IGF-1 deficiency (Primary IGFD)
❑ Other diagnosis: ________________________ ICD-10 Code(s): ________________________

For growth hormone gene deletion, answer the following:

Has the patient developed neutralizing antibodies to growth hormone? ❑ **Yes** ❑ **No**
Does the patient have a known or suspected malignancy? ❑ **Yes** ❑ **No**
Does the patient have closed epiphyses? ❑ **Yes** ❑ **No**
Is the patient concurrently taking growth hormone therapy? ❑ **Yes** ❑ **No**

For severe primary IGF-1 deficiency, answer the following:

Does the patient have a height standard deviation score less than or equal to -3.0? ❑ **Yes** ❑ **No**
Does the patient have a basal IGF-1 standard deviation score less than or equal to -3.0? ❑ **Yes** ❑ **No**
Does the patient have normal or elevated growth hormone? ❑ **Yes** ❑ **No**
Does the patient have a known or suspected malignancy? ❑ **Yes** ❑ **No**
Does the patient have closed epiphyses? ❑ **Yes** ❑ **No**
Is the patient concurrently taking growth hormone therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had an increase in growth velocity from baseline? ❑ **Yes** ❑ **No**
Has the patient had annual clinical re-evaluation by the treating endocrinologist? ❑ **Yes** ❑ **No**
Does the patient have a known or suspected malignancy? ❑ **Yes** ❑ **No**
Does the patient have closed epiphyses? ❑ **Yes** ❑ **No**
Is the patient concurrently taking growth hormone therapy? ❑ **Yes** ❑ **No**

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

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Please note: This request may be denied unless all required information is received.

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