



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

Increlex® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Select the diagnosis below:

Growth failure in children

Severe primary insulin-like growth factor-1 deficiency (primary IGFD)

Growth hormone gene deletion with developed neutralizing antibodies to growth hormone

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is Increlex prescribed by an endocrinologist? Yes No

Does the patient have a height standard deviation (SD) score of less than or equal to 3.0 SD scores below normal (growing at or below the third percentile for age and gender)? Yes No

Does the patient have a baseline IGF-1 SD score of less than or equal to 3.0 SD scores below normal (based on age- and gender-related reference ranges)? Yes No

Does the patient have normal or elevated GH level (based on GH stimulation testing) or (for children with GH gene deletion) measured titers of GH-neutralizing antibodies? Yes No

Does the patient have open epiphyses (bone growth plates)? Yes No

Does the patient have bone age less than 14 years for girls or less than 16 years for boys? Yes No

Continuation:

Does the patient have a growth velocity greater than or equal to 2.5 cm/year? Yes No

Is the patient being evaluated yearly by an endocrinologist? Yes No

Has the patient obtained his/her expected adult height? Yes No

Please specify expected adult height goal (include units of measurement): _____

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.

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