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

Increlex® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ 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.