maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Increlex

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGFD) in a child (If checked, go to 2) [] Growth hormone (GH) gene deletion in a child who has developed neutralizing antibodies to GH (If checked, go to 3) [] Idiopathic short stature, growth hormone deficiency (If checked, no further questions) [] Other (If checked, no further questions)		
2	Has the patient been on the requested medication for greater than or equal to 1 year?	Yes	No

If you have any questions, call:
1-888-258-8250

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	[If yes, skip to question 4.] [If no, skip to question 5.]		
3	Has the patient been on the requested medication for greater than or equal to 1 year? [If no, skip to question 7.]	Yes	No
4	Has the patient's height increased by greater than or equal to 4 cm/year in the most recent year? [NOTE: Patients are reviewed annually for growth rate.] [If yes, skip to question 9.] [If no, no further questions.]	Yes	No
5	Is the patient greater than or equal to 2 years of age? If yes, please specify age: _____ [If no, no further questions.]	Yes	No
6	Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist? [If yes, skip to question 10.] [If no, no further questions.]	Yes	No
7	Is the patient greater than or equal to 2 years of age? If yes, please specify age: _____ [If no, no further questions.]	Yes	No
8	Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist? [No further questions.]	Yes	No
9	Are the patient's epiphyses open? [No further questions.]	Yes	No
10	At baseline, what is the patient's height standard deviation score (SDS)? [NOTE: For example: A SDS of -2.5 would be greater than -3.0, a SDS of -4.0 would be less than -3.0.] [] Less than or equal to -3.0 (If checked, go to 11) [] Greater than -3.0 (If checked, no further questions)		
11	Does the patient have a basal IGF-1 level below the lower limits of the normal reference range for the reporting laboratory? [NOTE: Reference ranges for IGF-1 vary among laboratories and are dependent upon age, gender, and puberty status.] [If no, no further questions.]	Yes	No
12	At baseline, is the growth hormone concentration normal or increased?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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