



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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy?	
	<input type="checkbox"/> Initial (If checked, go to 6)	
	<input type="checkbox"/> Continuation (If checked, go to 2)	
2	Is the patient currently receiving the requested medication? [If no, skip to question 6.]	Yes No

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 6.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]	Yes	No
5	Has the patient been taking the requested medication for AT LEAST 3 months and has experienced a clinically significant benefit from the medication, as documented by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
6	What is the diagnosis or indication? <input type="checkbox"/> Severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGFD) in a child (If checked, go to 7) <input type="checkbox"/> Growth hormone (GH) gene deletion in a child who has developed neutralizing antibodies to GH (If checked, go to 15) <input type="checkbox"/> Other (If checked, no further questions)		
7	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
8	Are the patient's epiphyses open? [If no, no further questions.]	Yes	No
9	Has documentation been submitted to confirm the patient's height standard deviation score (SDS)? ACTION REQUIRED: Submit supporting documentation. [NOTE: For example: A SDS of -2.5 would be greater than -3.0, and a SDS of -4.0 would be less than -3.0.] <input type="checkbox"/> Less than or equal to -3.0 (If checked, go to 10) <input type="checkbox"/> Greater than -3.0 (If checked, no further questions)		
10	Has documentation been submitted to confirm that the patient has a basal insulin-like growth factor-1 (IGF-1) level less than or equal to 3 at baseline? ACTION REQUIRED: Submit supporting documentation. [NOTE: Baseline is prior to initiation of treatment with the requested medication. Reference ranges for IGF-1 vary among laboratories and are dependent upon age, gender, and puberty status.] [If no, no further questions.]	Yes	No
11	At baseline, is the growth hormone concentration normal or increased?	Yes	No

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[If no, no further questions.]

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|----|---|-----|----|
| 12 | Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist?
[If no, no further questions.] | Yes | No |
| 13 | Will the patient be receiving concurrent treatment with growth hormone?
[If yes, no further questions.] | Yes | No |
| 14 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: Children greater than or equal to 2 years and Adolescents: 0.04 to 0.08 mg/kg/dose SQ twice daily.]
[No further questions.] | Yes | No |
| 15 | Is the patient greater than or equal to 2 years of age?
[If no, no further questions.] | Yes | No |
| 16 | Are the patient's epiphyses open?
[If no, no further questions.] | Yes | No |
| 17 | Has documentation been submitted to confirm the patient has developed neutralizing antibodies to growth hormone? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 18 | Will the patient be receiving concurrent treatment with growth hormone?
[If yes, no further questions.] | Yes | No |
| 19 | Is the requested medication being prescribed by or in consultation with a pediatric endocrinologist?
[If no, no further questions.] | Yes | No |
| 20 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Dosing: Children greater than or equal to 2 years and Adolescents: 0.04 to 0.08 mg/kg/dose SQ twice daily.] | Yes | No |

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

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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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