



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Increlex (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Increlex (Medicare Determination).

Drug Name (select from list of drugs shown)

Increlex (mecasermin)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Is the patient 2 years of age or older? | Y | N |
| 3. Does the patient have closed epiphyses? | Y | N |
| 4. Does the patient have the presence of active or suspected neoplasia? | Y | N |
| 5. Does the patient have a diagnosis of severe primary insulin-like growth factor-1 (IGF-1) deficiency (Primary IGF1)?
(e.g., mutation in the GH-receptor, mutation in the post-GHR signaling pathway, IGF-1 gene defects)
[If the answer to this question is yes, then may skip to question 8.] | Y | N |
| 6. Does the patient have a diagnosis of growth hormone gene deletion? | Y | N |
| 7. Has the patient developed neutralizing antibodies to growth hormone? | Y | N |
| 8. Has the patient received Increlex therapy for at least one year through a Caremark pharmacy benefit?
[If the answer to this question is yes, then may skip to question 11.] | Y | N |
| 9. Was the height of the patient greater than or equal to 3 standard | Y | N |



Arkansas BlueCross BlueShield

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deviations below the norm for children of the same age and gender prior to beginning Increlex therapy?

- | | | |
|--|---|---|
| 10. Does the patient have a basal IGF-1 level greater than or equal to 3 standard deviations below the norm for children of the same age and gender prior to beginning Increlex therapy?
[No further questions required.] | Y | N |
| 11. Has the patient displayed an increase in height velocity of 2 cm/year within the first year of Increlex therapy? | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date