



Prior Authorization Form

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

Drug Name (select from list of drugs shown)
Iplex (mecasermin rinfabate)

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 3 years of age or older? | Y | N |
| 3. Does the patient have closed epiphyses? | Y | N |
| 4. Does the patient have a diagnosis of severe primary IGF-1 deficiency? [If the answer to this question is yes, then skip to question 7.] | Y | N |
| 5. Does the patient have a diagnosis of growth hormone gene deletion? | Y | N |
| 6. Has the patient developed neutralizing antibodies to growth hormone? | Y | N |
| 7. Has the patient been receiving IPLEX therapy? [If the answer to this question is yes, then skip to question 10.] | Y | N |
| 8. Is the height of the patient greater than or equal to 3 standard deviations below the norm for children of the same age and gender? | Y | N |
| 9. 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 | Y | N |



Arkansas BlueCross BlueShield

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age and gender?

[Skip to question 10.]

- | | | | |
|-----|---|---|---|
| 10. | Did the height velocity during the first year of therapy increase by at least 2 cm/year? | Y | N |
| 11. | Have thyroid and/or nutritional deficiencies been corrected? | Y | N |
| 12. | Does the patient have a growth hormone deficiency confirmed by failing a growth hormone stimulation test? | Y | N |
| 13. | Have other secondary causes of growth failure been ruled out? | Y | N |
| 14. | Does the patient have the presence of active or suspected neoplasia? | 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