



CONTAINS CONFIDENTIAL PATIENT INFORMATION

Increlex

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 844-474-3341.

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient phone #: _____	Physician Specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

Increlex	<input type="checkbox"/> 40 mg/4 mL Vial	_____	Specify: _____
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7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

Note: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient is 2 to 17 years of age
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a diagnosis of short stature or dwarfism in the last 730 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a diagnosis of growth failure due to GH gene deletion/deficiency/mutation or neutralizing antibodies in the last 730 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a diagnosis of growth hormone deficiency in the last 730 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has low GH levels (evoked GH less than or equal to 7ng/mL) in the last 730 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a height standard deviation score less than or equal to -3.0 in the last 90 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a basal IGF-1 standard deviation score less than or equal to -3.0 in the last

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	90 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a diagnosis of an open epiphysis in the last 90 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a diagnosis of CRD, pituitary tumors, hypothyroidism, or chromosomal abnormalities in the last 730 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a diagnosis of malignancy or malnutrition in the last 365 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a history of antineoplastics (specific for mecasermin) in the last 365 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has a history of chemotherapy CPTs in the last 365 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	The requested dose is less than or equal to 0.24mg/kg/day

9. PHYSICIAN SIGNATURE

_____	_____
Prescriber or Authorized Signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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