

## **Increlex (mecasermin, recombinant, rh-IGF-1) Prior Authorization Request Form**



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

			☐ URGENT	
MEMBER INFORMATION				
LAST NAME:	NAME:		FIRST NAME:	
PHONE NUMBER:		DATE OF BIRTH:	DATE OF BIRTH:	
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
PATIENT INSURANCE ID NUM	/IBER:			
IF YOU ARE NOT THE PATIENT OR THE PRESCRI FOLLOWING LINK: <u>HTTPS://MAGELLANRX.COM</u>	BER, YOU WILL NEED TO SUBMIT A PHI DI	MMON/DOC/EN-US/PHI DISCLOSURE AUTH	IS REQUEST WHICH CAN BE FOUND AT THE HORIZATION.PDF	
PATIENT'S AUTHORIZED REPR AUTHORIZED REPRESENTATIV				
PRESCRIBER INFORMATION				
LAST NAME:		FIRST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CODE:		
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSON:		
MEDICATION OR MEDICAL I	DISPENSING INFORMATION			
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
■ NEW THERAPY ■ RENEWAL DURATION OF THERAPY (SPECIFIC DATES):		IF RENEWAL: DATE THER	IF RENEWAL: DATE THERAPY INITIATED:	
Continued on next page.				



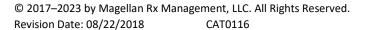


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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:		
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO	
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	<b>DURATION OF THERAPY</b> (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:	
2. LIST DIAGNOSES:		ICD-10:	
□ Severe primary insulin-like grow th facto □ Other Diagnosis ICD-10 C *Please provide chart documentation (i.e., 3. REQUIRED CLINICAL INFORMATION	ode(s):		
PRIOR AUTHORIZATION.			
Clinical Information: Is Increlex being prescribed by an ende	ocrinologist?   Yes   No		
Does the patient have normal to eleva documentation.)	ited grow th hormone levels?* $\square$ Yes $\square$	No (Please provide chart	
Does the patient have a grow th horm growth hormone?* □ Yes □ No (Pleas	one gene deletion and has the patient of general contraction.	developed neutralizing antibodies to	
Does the patient have a height standa  □ No (Please provide chart document	rd deviation score of negative 3.0 or les	ss prior to starting treatment?*   Yes	
Does the patient have a basal IGF-1 st Yes □ No (Please provide chart docur	andard deviation score of negative 3.0 on mentation.)	or less prior to starting treatment?* $\ \square$	
Are the patient's epiphyses closed?* *Please provide chart documentation	□ Yes □ No (i.e., chart notes) supporting this inform	nation.	
Does the patient have an active or sus	pected malignancy?  ☐ Yes ☐ No (Please	provide chart documentation.)	
□ Yes □ No	o answer the following question: to therapy, defined as a minimum grow (i.e., chart notes) supporting this inform		
Are there any other comments, diagnosphysician feels is important to this rev	oses, symptoms, medications tried or fa iew?	iled, and/or any other information the	









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**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** 

Date:

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640** 

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811

