Mecasermin (Increlex) Prior Authorization Request Form

5587

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php

Drug for which Prior Authorization is requested: **Mecasermin (Increlex)**

Step 1 **Please complete patient and physician information (Please Print)**

Patient Name: ____________________ Physician Name: ____________________

Address: ____________________ Address: ____________________

____________________ ____________________

Sponsor ID #: ____________________ Phone #: ____________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment**

Question	Yes	No
1. Is the patient a child older than two years of age with open epiphyses?	☐ Yes Please proceed to question 2	☐ No Coverage not approved
2. Is the patient receiving ongoing care under the guidance of a health care provider skilled in diagnosis and management of growth disorders (e.g., pediatric endocrinologist)?	☐ Yes Please proceed to question 3	☐ No Coverage not approved
3. Does the patient have severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD), defined by the following: ▪ **Height standard deviation score < -3 AND** ▪ **Basal IGF-1 standard deviation score < -3 AND** ▪ **Normal or elevated growth hormone levels**	☐ Yes Please proceed to question 5	☐ No Please proceed to question 4
4. Does the patient have growth hormone gene deletion AND neutralizing antibodies to growth hormone?	☐ Yes Please proceed to question 5	☐ No Coverage not approved
5. Does the patient have any of the following: ▪ **Other causes of growth failure (e.g., growth hormone deficiency, malnutrition, hypothyroidism, chronic anti-inflammatory steroid use)** ▪ **Active or suspected neoplasia**	☐ Yes Coverage not approved	☐ No Please proceed to question 6
6. Has the patient and/or caregiver been educated on how to monitor blood glucose levels, received a glucometer and necessary testing supplies, and demonstrated knowledge of blood glucose monitoring and hypoglycemia management?	☐ Yes Coverage approved for 1 year	☐ No Coverage not approved

Step 3 **I certify the above is correct and accurate to the best of my knowledge** (Please sign and date)

____________________ Prescriber Signature ____________________ Date

Latest revision: Aug 2007