Reset Form Print Form

FLORIDA MEDICAID PRIOR AUTHORIZATION

Increlex®

Note: Form must be completed in full.
An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

○ **Initiation of Therapy** – complete form and submit all relevant supporting documentation.

-OR-

○ **Continuation of Therapy** – complete form and submit supporting documentation which should include a **growth chart** demonstrating progression of growth greater than or equal to 2 cm total in one year and final adult height has not been reached.

Diagnoses: (Please check all that apply and submit supporting lab work and documentation.)

☐ **Increlex®** for patient with severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD) defined by:

- Height standard deviation score ≤ -3 AND
- Basal IGF-1 standard deviation score ≤ -3 AND
- Normal or elevated growth hormone level (greater than 10ng/ml on standard GH stimulation tests) **OR**

☐ **Increlex®** for patient with growth hormone gene deletion who has developed neutralizing antibodies to growth hormone. **(Must submit supporting documentation.)**

Complete Assessment:

1.	Is the patient a child older than two years of age with open epiphyses?	○ Yes	○ No
2.	Is the patient receiving ongoing care from an endocrinologist? Is the current prescriber an endocrinologist?	○ Yes	○ No
3.	Does the patient have growth failure related to growth hormone deficiency, malnutrition, hypothyroidism, or chronic anti-inflammatory steroid use? *(Thyroid and nutritional deficiencies should be corrected before initiation of Increlex®)*	○ Yes	○ No
4.	Does the patient have active or suspect neoplasia?	○ Yes	○ No

Prescriber's Signature: _____ Date: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Call or Fax Information to: Florida Community Care Prior Authorization
Phone number for non-specialty Prior Authorization: 877-433-7643
Phone number for specialty Prior Authorization: 866-814-5506
Fax number for non-specialty Prior Authorization: 866-255-7569
Fax number for non-specialty Prior Authorization: 866-249-6155