

## FLORIDA MEDICAID PRIOR AUTHORIZATION

Increlex®



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

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Rec	pien	t's F	ull N	ame																							
Prescriber's Full Name																											
Pres	crib	er's	NPI																								
Prescriber Phone Number								Prescriber Fax Number																			
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**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**<sup>®</sup> 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<sup>®</sup> 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? ( <i>Thyroid and nutritional deficiencies should be corrected before initiation of Increlex®</i> )	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 **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 (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.