UPMC HEALTH PLAN

INCRELEX
Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		**Provider Specialty:**	
Provider First Name:		**Provider Last Name:**	
Provider Phone:		**Provider Fax:**	**Provider NPI #:**
Patient Name:	**Patient UPMC Health Plan ID Number:**	**Patient DOB:**	**Patient Age:**

Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Qty Dispensed:**	**Anticipated duration of use?**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ **New Medication** ❑ **Ongoing Medication**	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	❑ **Yes** ❑ **No**

Diagnosis:		**Patient Height:**	**Patient Weight:**
Please indicate place of administration:	❑ Physician's Office ❑ Hospital/Clinic	**Will the drug be: (select one)** ❑ Billed directly by the provider via JCODE JCODE: _____ ❑ Billed by a pharmacy and delivered to the provider ❑ Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			

MEDICAL HISTORY

Please indicate the most appropriate diagnosis:

- ❑ **Severe primary IGF-1 deficiency**
- ❑ **Growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH**
- ❑ **Other:** _____

Please provide chart documentation and lab results for the following:

- ❑ **Present height percentile:** _____ **Pretreatment growth velocity:** _____
- ❑ **Bone age:** _____ **Chronological age:** _____
- ❑ **Basal serum IGF-1 level:** _____ **Growth hormone stimulation tests and the agent used:** _____

Documentation of growth chart and the treatment plan outlining dose, monitoring parameters (such as follow-up) and methods for determining treatment response

Does the member have any of the following secondary forms of IGF-1 deficiency:

- ❑ **Growth hormone deficiency**
- ❑ **Malnutrition**
- ❑ **None**
- ❑ **Hypothyroidism**
- ❑ **Chronic treatment with pharmacologic doses of anti-inflammatory steroids**

Is the member currently taking growth hormone?	❑ **Yes** ❑ **No**
Does the member have active or suspected neoplasia?	❑ **Yes** ❑ **No**
Does the member have an allergy to mecasermin?	❑ **Yes** ❑ **No**

For Reauthorization:

- ❑ **Growth velocity prior to therapy:** _____ **Growth velocity will on therapy:** _____
- ❑ **Bone age:**_____ **Chronological age:**_____
- ❑ **Documentation of the growth chart and treatment plan outlining dose, monitoring parameters (such as follow-up) and documentation showing an adequate treatment response**