Wellpoint

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

# Increlex

**Prior Authorization of Benefits (PAB) Form**
**Complete form in its entirety and fax to:**
**Prior Authorization of Benefits Center at 844-474-3341.**

| 1. PATIENT INFORMATION | 2. PHYSICIAN INFORMATION |
|---|---|
| Patient name: _____ | Prescribing Physician: _____ |
| Patient ID #: _____ | Physician Address: _____ |
| Patient DOB: _____ | Physician Phone #: _____ |
| Date of Rx: _____ | Physician Fax #: _____ |
| Patient phone #: _____ | Physician Specialty: _____ |
| Patient email address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician Email Address: _____ |

| 3. MEDICATION | 4. STRENGTH | 5. DIRECTIONS | 6. QUANTITY PER 30 DAYS |
|---|---|---|---|
| Increlex | ☐ 40 mg/4 mL Vial | _____ | Specify: _____ |

**7. DIAGNOSIS:** _____

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**
**Note: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

☐ Yes ☐ No Patient is 2 to 17 years of age
☐ Yes ☐ No Patient has a diagnosis of short stature or dwarfism in the last 730 days
☐ Yes ☐ No Patient has a diagnosis of growth failure due to GH gene eletion/deficiency/mutation or neutralizing antibodies in the last 730 days
☐ Yes ☐ No Patient has a diagnosis of growth hormone deficiency in the last 730 days
☐ Yes ☐ No Patient has low GH levels (evoked GH less than or equal to 7ng/mL) in the last 730 days
☐ Yes ☐ No Patient has a height standard deviation score less than or equal to -3.0 in the last 90 days
☐ Yes ☐ No Patient has a basal IGF-1 standard deviation score less than or equal to -3.0 in the last



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| | |
|---|---|
| | 90 days |
| ☐ Yes ☐ No | Patient has a diagnosis of an open epiphysis in the last 90 days |
| ☐ Yes ☐ No | Patient has a diagnosis of CRD, pituitary tumors, hypothyroidism, or chromosomal abnormalities in the last 730 days |
| ☐ Yes ☐ No | Patient has a diagnosis of malignancy or malnutrition in the last 365 days |
| ☐ Yes ☐ No | Patient has a history of antineoplastics (specific for mecasermin) in the last 365 days |
| ☐ Yes ☐ No | Patient has a history of chemotherapy CPTs in the last 365 days |
| ☐ Yes ☐ No | The requested dose is less than or equal to 0.24mg/kg/day |

**9. PHYSICIAN SIGNATURE**

| | |
|---|---|
| _____ | _____ |
| Prescriber or Authorized Signature | Date |

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.*
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.



Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.