



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/complecare-forproviders/pharmacy

Increlex Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

| Member Information | | | | | |
|---|----------------|---|--|---|---|
| Member Name (first & last): | Date of Birth: | Gender: | | Height: | |
| | | <input type="checkbox"/> Male | <input type="checkbox"/> Female | | |
| Member ID: | City: | State: | | Weight: | |
| Prescribing Provider Information | | | | | |
| Provider Name (first & last): | Specialty: | NP# | | DEA# | |
| Office Address: | City: | State: | | Zip Code: | |
| Office Contact: | | Office Phone | | Office Fax: | |
| Dispensing Pharmacy Information | | | | | |
| Pharmacy Name: | | Pharmacy Phone: | | Pharmacy Fax: | |
| Requested Medication Information | | | | | |
| Medication request is NOT for an FDA approved, or compendia supported diagnosis (circle one): Yes No | | ICD-10 Code: | | Diagnosis: | |
| What medication(s) have been tried and failed for diagnosis? | | | | | |
| Are there any contraindications to formulary medications? If yes, please specify: | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Directions for Use: | | Strength: | | Dosage Form: | |
| | | Quantity: | Day Supply: | Duration of Therapy/Use: | |
| Turn-Around Time for Review | | | | | |
| <input type="checkbox"/> Standard – (24 hours) | | <input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____ | | | |
| Clinical Information | | | | | |
| Does member have evidence of epiphyseal closure OR active OR suspected neoplasia? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is there a diagnosis of GH gene deletion with development of neutralizing antibodies to GH? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Is there a diagnosis of severe, primary IGF-1 deficiency? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Please check that apply: | | <input type="checkbox"/> Height standard deviation score ≤ -3 | <input type="checkbox"/> Basal IGF-1 standard deviation score ≤ -3 | <input type="checkbox"/> Normal or high GH levels (>10ng/mL on standard GH stimulation tests) | |
| Is there evidence of secondary forms of IGF-1 deficiency (for example, GH deficiency, malnutrition, hypothyroidism or chronic treatment with pharmacologic doses of corticosteroids)? | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <input type="checkbox"/> Renewal Requests ONLY: | | | | | |
| Did member have at least a doubling of pre-treatment growth velocity? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Did member have a growth velocity of ≥2.5 cm/yr? | |
| Provider confirms ALL the following: | | <input type="checkbox"/> Documentation of growth charts | <input type="checkbox"/> Epiphyses are open | <input type="checkbox"/> Member has no active or suspected neoplasia | <input type="checkbox"/> Member is not on concurrent GH therapy |
| Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records | | | | | |

Large empty rectangular box for chart notes.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required
Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.