Mecasermin (Increlex) Prior Authorization Request Form

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Drug for which Prior Authorization is requested: **Mecasermin (Increlex)**

Step 1 **Please complete patient and physician information (Please Print)**

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID #: ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment**

Question	Yes	No
1. Is the patient a child older than two years of age with open epiphyses?	☐ Yes Please proceed to question 2	☐ No Coverage not approved
2. Is the patient receiving ongoing care under the guidance of a health care provider skilled in diagnosis and management of growth disorders (e.g., pediatric endocrinologist)?	☐ Yes Please proceed to question 3	☐ No Coverage not approved
3. Does the patient have severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD), defined by the following: ▪ **Height standard deviation score $\leq$ -3 AND** ▪ **Basal IGF-1 standard deviation score $\leq$ -3 AND** ▪ **Normal or elevated growth hormone levels**	☐ Yes Please proceed to question 5	☐ No Please proceed to question 4
4. Does the patient have growth hormone gene deletion AND neutralizing antibodies to growth hormone?	☐ Yes Please proceed to question 5	☐ No Coverage not approved
5. Does the patient have any of the following: ▪ **Other causes of growth failure (e.g., growth hormone deficiency, malnutrition, hypothyroidism, chronic anti-inflammatory steroid use)** ▪ **Active or suspected neoplasia**	☐ Yes Coverage not approved	☐ No Please proceed to question 6
6. Has the patient and/or caregiver been educated on how to monitor blood glucose levels, received a glucometer and necessary testing supplies, and demonstrated knowledge of blood glucose monitoring and hypoglycemia management?	☐ Yes Coverage approved for 1 year	☐ No Coverage not approved

Step 3 **I certify the above is correct and accurate to the best of my knowledge** (Please sign and date)

______________________ Prescriber Signature

______________________ Date

Latest revision: Aug 2007

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For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: