

US Family Health Plan Prior Authorization Request Form for Mecasermin (Increlex)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through US Family Health Plan Mail Order Pharmacy OR the US Family Health Plan Retail Pharmacy Network.

<p>Complete this form and submit it with the prescription to US Family Health Plan by EITHER:</p> <p>Fax: 1-617-562-5296 OR Mail: US Family Health Plan Attn: Pharmacy 77 Warren Street Boston, MA 02135</p>	<p>Please indicate whether the prescription is to be filled:</p> <p><input type="checkbox"/> through the US Family Health Plan Mail Order Pharmacy OR <input type="checkbox"/> at a retail network pharmacy</p>
--	--

This form is available at: http://www.usfamilyhealthplan.org/facility/site_content.asp?s=110.

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

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

1 Patient Name: _____ Physician Name: _____
 Address: _____ Address: _____
 Sponsor ID #: _____ Phone #: _____
 Secure Fax #: _____

Step 2 Please complete the clinical assessment

1. Is the patient a child older than two years of age with open epiphyses?	<input type="checkbox"/> Yes Please proceed to question 2	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes Please proceed to question 3	<input type="checkbox"/> No Coverage not approved
3. Does the patient have severe primary insulin-like growth factor (IGF)-1 deficiency (IGFD), defined by the following: <ul style="list-style-type: none"> ▪ Height standard deviation score ≤ -3 AND ▪ Basal IGF-1 standard deviation score ≤ -3 AND ▪ Normal or elevated growth hormone levels 	<input type="checkbox"/> Yes Please proceed to question 5	<input type="checkbox"/> No Please proceed to question 4
4. Does the patient have growth hormone gene deletion AND neutralizing antibodies to growth hormone?	<input type="checkbox"/> Yes Please proceed to question 5	<input type="checkbox"/> No Coverage not approved
5. Does the patient have any of the following: <ul style="list-style-type: none"> ▪ Other causes of growth failure (e.g., growth hormone deficiency, malnutrition, hypothyroidism, chronic anti-inflammatory steroid use) ▪ Active or suspected neoplasia 	<input type="checkbox"/> Yes Coverage not approved	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Coverage approved for 1 year	<input type="checkbox"/> No Coverage not approved

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

3 _____

Prescriber Signature

Date