ProCare Rx

Increlex® mecasermin

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Increlex®. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC # and GCN:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information)

☐ Initiation of Therapy: Complete form and submit all relevant supporting documentation.

- OR –

☐ Continuation of Therapy: Complete form and submit supporting documentation which should include a growth chart demonstrating progression of growth since initiation of therapy.

Diagnosis: (Check all that apply and submit supporting lab work and documentation.)

☐ Increlex® for patient with severe primary insulin-like growth factor (IGF-1) deficiency (IGFD) defined by:

- Height standard deviation score ≤ -3
- Basal IGF-1 standard deviation score ≤ -3
- Normal or elevated growth hormone level

☐ Increlex® for patient with growth hormone gene deletion who has developed neutralizing antibodies to growth hormone.

MUST SUBMIT SUPPORTING DOCUMENTATION

Complete Assessment: (Please circle all that apply)

1.	Is the patient a child older than two years of age with open epiphyses?	YES	NO
2.	Is the patient receiving ongoing care from an endocrinologist?	YES	NO
3.	Is the current prescriber an endocrinologist?	YES	NO
4.	Does the patient have growth failure related to growth hormone deficiency, malnutrition, hypothyroidism, or chronic anti-inflammatory steroid use? (Thyroid and nutritional deficiencies should be corrected before ignition of Increlex®)	YES	NO
5.	Does the patient have active or suspect neoplasia?	YES	NO

Authorized Medical Signature:

Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.