

UPMC HEALTH PLAN

INCRELEX

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:	Provider Specialty:
Provider First Name:	Provider Last Name:
Provider Phone:	Provider Fax:

Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
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Strength:	Frequency:	Qty Dispensed:	Patient Height:	Patient Weight:	Anticipated duration of use?
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<input type="checkbox"/> Brand <input type="checkbox"/> Generic	<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Place of infusion? (Name and Location) <input type="checkbox"/> Physician's Office: <input type="checkbox"/> Hospital/Facility:	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE If billed via JCODE, please provide the name of provider or vendor that will bill for this drug: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient
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MEDICAL HISTORY

Please indicate the most appropriate diagnosis:

Severe primary IGF-1 deficiency

Growth hormone (GH) gene deletion who have developed neutralizing antibodies to GH

Other: _____

Please provide chart documentation and lab results for the following:

Present height percentile: _____

Pretreatment growth velocity: _____

Bone age: _____ Chronological age: _____

Basal serum IGF-1 level: _____

Growth hormone stimulation tests and the agent used: _____

Documentation of growth chart and the treatment plan outlining dose, monitoring parameters (such as follow-up) and methods for determining treatment response

Does the member have any of the following secondary forms of IGF-1 deficiency:

Growth hormone deficiency

Malnutrition

Hypothyroidism

Chronic treatment with pharmacologic doses of anti-inflammatory steroids

None

Is the member currently taking growth hormone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the member have active or suspected neoplasia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does the member have an allergy to mecasermin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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For Reauthorization:

Growth velocity prior to therapy: _____ Growth velocity will on therapy: _____

Bone age: _____ Chronological age: _____

Documentation of the growth chart and treatment plan outlining dose, monitoring parameters (such as follow-up) and documentation showing an adequate treatment response

