AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Increlex® (mecasermin)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization: 12 months

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Diagnoses:		
❑ Severe primary insulin-like growth factor-1 (IGF-1) deficiency	❑ Growth hormone gene deletion	❑ Other (please specify):

Clinical Information:			
Pre-treatment height: _____		**Pre-treatment age:** _____	
Pre-treatment IGF-1 value (normal range _____) (Less than or equal to 3 standard deviations below the mean for age and gender)		**Pre-treatment Growth Hormone Level (normal range _____) (Normal or elevated growth hormone levels)**	
Date: _____	**Value**: _____	**Date**: _____	**Value**: _____

❑ **For diagnosis of Growth hormone gene deletion:**

❑ Neutralizing antibodies to GH ❑ Yes ❑ No ❑ DATE: _____

Reauthorization: 12 months. Coverage for continuation of therapy requires meeting current initial use criteria and evaluation of response as shown by growth rate velocity. Coverage for growth promotion will cease when the bony epiphyses have closed. Yearly reassessment for reauthorization of coverage is required

❑ If 16 years of age or older, provide appropriate **yearly** documentation to confirm epiphyses are not closed

❑ Growth rate velocity must be ≥ 2.5 cm/year

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: 5/17/2013
REVISED/UPDATED/REFOMATTED: ~~6/14/13~~; ~~4/7/2014~~; ~~10/20/2014; 11/6/2014;~~ ~~5/21/2015~~; ~~12/28/2015~~; ~~12/19/2016; 8/14/2017~~; ~~(Reformatted) 6/18/2019;8/26/2022;~~ **10/27/2023**;